DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Kamala Fiske-Downing

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

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. <u>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.</u>

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/28/2020 through 7/30/2020, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaint (was/were) found to be substantiated: H5617008C. Deficiency issued at F Tag F760 The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F760 began on 7/30/2020, when a resident (R1) received 2 doses of morphine 16 times higher than the dose that was ordered, this resulted in unresponsiveness, hypoxia, and respiratory distress. R1 was not monitored as ordered during the overdose and did to receive the naloxone dose that was ordered. This had the potential to cause serious injury or death. The administrator, and DON were notified of the IJ for R1 on 7/29/20 at 3:51 p.m. The IJ was removed on 7/30/20, at 4:00 p.m. In addition, an extended survey was completed on 7/30/20, related to the substandard quality of care findings. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This 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 (IJ) situation for R1 who received a dose of morphine (a narcotic analgesic) sixteen times the dose ordered, resulting in unresponsiveness, hypoxia (low oxygen level) and respiratory distress. The physician ordered a medication to reverse the effects of the morphine overdose, the order was again transcribed incorrectly and a dose was administered to R1 less than what was ordered and via the wrong route of administration. This resulted in drowsiness and intermittent unresponsiveness, hypoxia, and respiratory distress for R1 for over 24 hours. The immediate jeopardy began on 7/24/20, when two significant medication errors occurred for R1. The facility administrator, director of nursing (DON) and the facility campus administrator were notified of the immediate jeopardy at 3:51 p.m. on	F 760	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 a 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	8/24/20

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F 760	Continued From page 2 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. Findings include: R1's significant change Minimum Data Set (MDS) dated 7/1/20, included moderate cognitive impairment, required extensive to total assistance with most activities of daily living (ADL's), had pain daily at a level 8 (on a 0-10 scale with 0 being no pain and 10 being excruciating/unmanageable pain), had shortness of breath with exertion, and received an opioid (narcotic) medication 7 out of the 7 day look back period. R1 had diagnoses that included, hip fracture, heart failure, and Alzheimer's disease. R1's care plan dated 7/15/20, included a recent femur fracture, staff were directed to provide medications as ordered. Hospice care was added to the care plan on 7/20/20 for a diagnosis of Alzheimer's disease. R1's medication administration record (MAR) dated 7/20/20, included an order for, "Morphine Sulfate (concentrate) Solution 20 MG/ML (milligrams per milliliters) give 0.25 ml [5 mg] by mouth every 4 hours for Pain. DO NOT AWAKE TO GIVE MEDICATION." R1's Hospice progress note dated 7/24/20, 2:46 p.m. included, "Writer reviewed EHR [electronic health record] and then spoke with facility nurse [name of nurse]. She indicated that [R1's name] overall does not look good. She indicated that held 0800 [8:00 a.m.] dose of morphine as patient	F 760	R1 remained in the facility and continued on hospice care until she passed. She passed away on 8/9/20. An audit was completed on all other residents with an order for liquid Morphine, as soon as the error was known, to verify accurate orders were in place. RN-A and RN-D were put on administrative leave. RN-A was terminated and reported to the MN Board of Nursing per reporting requirements. RN-D was given reeducation and corrective action per the progressive disciplinary policy and returned to work. RN-D was audited on medication administration upon return to work. The Narcan Policy and procedure were reviewed and were updated. Staff education regarding Narcan/EKit policy was initiated and is ongoing. Weekly audits for 6 weeks will be completed on the Ekit to ensure adequate stock is available. On 7/28/20 the facility Completed Medication Administration Audits on all Nurses and TMA's. Order Transcription Audits were completed on all new orders from 7/25/20 – current and ongoing. These audits are to ensure ongoing compliance with order transcription and staff's ability to safely pass medications to ensure compliance for 2 weeks and random weekly for 6 weeks. Results will be reviewed by the QA committee for ongoing compliance. The Clinical Administrator/Designee is responsible for	

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F 760	Continued From page 3 was asleep. Writer indicated that would remove part of the order that says HOLD IF ASLEEP. Writer instructed [nurse] regarding how to slide syringe inside cheek if asleep, and also giving a PRN [as needed] dose when awakens if scheduled dose held. In this way, will get caught up to base line dose, to manage symptoms. [Nurse] also indicated that patient is eating little. Writer informed her regarding family goal of decreasing Haldol [an antipsychotic medication often used for agitation/hallucinations/delusions when in dying process], but we may need to increase morphine if pain persists at present dose. Family is concerned about her being so sleepy. Writer went to [R1's] room. [R1] was sitting in her Broda Chair [reclining chair] dozing. She did arouse when name was stated. [R1] acknowledged that writer was new; writer explained that patient has always been asleep with [sic] writer came into room. Patient stated, 'I don't feel good.' She could not elaborate on that, and did not reply to questions about pain, writer noted that resps [respiratory] rate was elevated at 28 BPM [breaths per minute/normal is 12-16] Asked patient if was having difficulty catching breath, patient stated yes." R1's new physician order dated 7/24/20, included, "Morphine 20 mg/ml, give 5 mg po/sl, every 4 hours around the clock." However, the order was transcribed into the electronic medical record (EMR) and the medication administration record (MAR) by health information management specialist (HIMS)-A as, "Morphine sulfate (concentrate) solution 20 MG/ML, give 4 ml [80 mg] by mouth every 4 hours for Pain/Dyspnea, 5 mg = 4 ml." This resulted in the morphine dose being 16 times higher than the dose actually ordered by the physician. Registered nurse	F 760	ensuring compliance. The facility initiated and required all licensed nursing and TMA staff, including any newly hired nurses, to completed education on how to safely and correctly determine drug doses when calculations are required. This includes if there is any question about the calculation, that the medication should not be administered and should verify with another licensed nurse, or the pharmacy which is available 24 hours a day. Including that EMS may be summoned in acute reversible situations to ensure prompt attention to a resident. The education includes correct use of intradermal, intramuscular and subcutaneous syringes for administration. Audits will be completed daily for all new 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.	

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F 760	Continued From page 4	F 760		

(RN)-A signed off as double checking the order to ensure accuracy on 7/24/20, at 4:20 p.m.

R1's progress note dated 7/25/20, at 1:44 a.m. and written by RN-A included, "Writer gave 2 separate does of 4 mls of morphine to resident. First dose at 1640 [4:40 p.m.], second dose at 2100 [9:00 p.m.] 8 mls in total given to resident when it should have been 0.5 ml give for entire evening shift. Order was entered incorrectly in PCC [Point Click Care, the facilities EMR]; writer confirmed incorrect order and that is how medication error occurred. 2330 [11:30 p.m.] is when NOC [night] nurse went to go check on resident and found her RR [respiratory rate] 6-8 per minute [normal 12-16], HR [heart rate] 74 [normal 60-100] and 02 sats [oxygen level] 77% [normal 95-100%]. Noc nurse put resident on 2.5 liters of 02 [oxygen] via nasal cannula. Resident 02 went to 90% and later to 98%. Writer called hospice to inform of error and resident condition. Writer corrected error in PCC [the EMR] to reflect correct dosing of 0.25 mls per 4 hours. Writer received order to give 2mg of naloxone [a narcotic reversal medication] STAT [immediately] injection to resident, up to 10 mgs, until rousable and to proceed with 15 minute checks 8 times for 2 hours, then checks every hours for 6 hours. Resident was rousable after one administration. Writer then called POA [power of attorney] about error and resident condition. Resident is currently on 2.5 liters of O2, sats are 97%. RR 16-18 per minute. Pulse 75."

R1's Presbyterian Homes Hospice order dated 7/25/20, at 12:42 a.m. included, "Naloxone 2 mg IM [in the muscle] now- May be repeated every 2-3 minutes, as needed until client is rousable, with max dose of 10 mg. VS [vital signs] checks

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CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

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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 to R1. The report 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 muscle as ordered. In addition, the Naloxone had not been ordered from the pharmacy and therefore not available when needed in the morning for R1 when she became unresponsive again with

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periods of apnea.

R1's progress note dated 7/25/20, 4:08 p.m. included, "7:30 a.m. Night shift reported to writer that resident is arousable and respiration is 16 b/m [breaths per minute]; and response to yes or no questions. 7:45-10:00 a.m. writer took the full set of vital signs; respirations: 8-10 b/m, oxygen saturation: 94% on 2l/min [2 liters per minute] oxygen; BP [blood pressure] 110/70; t-[temperature] 98.2; p-[pulse] 76 b/m [beats per minute]; hospice nurse was informed about the residents ongoing health condition and informed that she did not get the proper dose of naloxone; naloxone was ordered from the pharmacy as a stat [immediate] order however the pharmacy told that it will take 2 hr [hours] for the process and arrival; family members was informed regarding the resident ongoing health condition and and [sic] give the option if she would like to send the resident to the hospital; responsible party told that she would like [sic] rely on the decision of the hospice nurse and would like to meet with the hospice nurse; hospice nurse was informed that family member want to meet the hospice nurse and leave the decision of the resident to the hospice nurse; hospice nurse arrived around 10:20 and family member was informed about the arrival of the nurse."

R1's progress note dated 7/25/20, 2:12 p.m. included, 10:30 a.m. "Seen resident not arousable accompanied by hospice nurse; hospice nurse stayed with resident in room; received information that hospice nurse is waiting for family member to come in and make decision if resident will be sent to ER [emergency room] or not." 10:50 a.m. "Resident's POA [power of attorney] arrived; made the decision of not to

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admit the resident to the hospital and to wait for the Narcan [brand name for naloxone] to be delivered; clinical administrator and clinical administrator [sic] was aware. Writer followed up with pharmacy re: time of arrival of Narcan and pharmacist informed writer that they are processing it and will be sent ASAP."

R1's progress note dated 7/25/20, 11:00 a.m. included, "Writer checked with AL [assisted living] clinical administrator for availability of Narcan in their E-kit; AL clinical administrator informed writer to check their medication room; found Narcan nasal spray in their medication cart, called AL clinical administrator again to inform and gave a go signal to use it if appropriate." "11:05 a.m. Writer approached hospice nurse and asked that since Narcan medication from pharmacy is still not available, if we can use the Narcan Nasal Spray; hospice nurse verbalized, "I will secure the order later for the spray." "11:10 a.m. Hospice nurse administered 4 mg of Narcan Nasal Spray, writer present as witness." "11:25 a.m. Resident became responsive and conversant; accompanied by sister in room." "12:45 p.m. Narcan injection was received from pharmacy; writer verified with hospice nurse if [sic] which form of Narcan (spray or injection) is to be given; hospice nurse confirmed to stick with the using the spray as indicated in the recent orders."

R1's progress note dated 7/25/20, 1:00 p.m. included, "Resident drank approximately 60 cc [cubic centimeters] of apple juice and ate a small portion of the cherry cake as reported by hospice nurse and her sister." 1:30 p.m. "Hospice nurse reported that she increase O2 @ 5 lpm via nasal cannula; resident is resting comfortably, sleepy

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but she is arousable to speech and touch; able to make short verbal responses." 2:10 p.m. "Resident is responsive to speech and touch; still accompanied by her sister."

R1's progress note dated 7/25/20, 4:00 p.m. included a respiratory rate of 12, oxygen level 90% on oxygen at 5 lpm, and resident was not arousable. 5:40 p.m. unable to open mouth for supper. 6:30 p.m. unable to arouse. 7:30 sleeping, respiratory rate of 12 and oxygen level of 99%. 9:00 p.m. R1 was not arousable. opened one eye during bed bath and made a noise. 10:20 p.m. respirations had dropped to 8 and the Narcan was administered again. 11:00 p.m. unable to arouse and all medications had been held. Although R1 had received doses of Narcan, she continued to have symptoms of respiratory depression and unresponsiveness as a result of the medication error.

R1's progress note dated 7/26/20, 7:29 a.m. noted respirations stable through the night, no apnea and did respond verbally when spoken to.

When interviewed on 7/28/20, at 2:30 p.m. HIMS-A stated RN-D had written a verbal order for the change in morphine on 7/24/20, HIMS-A transcribed the order into the EMR (Point Click Care). However, the order was written as Morphine 20 mg/ml, 5 mg every 4 hours, there was no milliliter equivalent and the PCC system would not take the order unless there was a milliliter designated for the amount. HIMS-A stated she did the math/drug calculation, by dividing the 20 mg by the 5 mg and came up with 4 milliliters, but was unsure she had calculated this correctly. She had never been trained to calculate drug doses, so she had RN-B review it

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and RN-B said it was good. She identified it is the facility policy to have a nurse check off on any orders processed by an HIMS, so RN-A signed off on the order later in the shift.

When interviewed on 7/28/20, at 12:45 p.m. RN-A stated, she had seen the order for R1's morphine in the computer as needing a nurse to sign off on it, she had assumed the dosage calculation had been done correctly and signed off on it without doing the dosage calculation herself. "I just signed what [HIMS-A] had written." RN-A stated she had given R1 the incorrect dose of morphine as it was transcribed, the 4 ml to equal 80 mg twice during her shift, not noting the discrepancy. When the night shift came on duty they did a narcotic count together and the night nurse [RN-D] noted there was too much morphine used and checked on R1 who was unresponsive and having apnea with respirations of only 8 per minute. This was how they found the medication error. She called hospice to report the error and R1's condition. Hospice returned the call and ordered the naloxone, she processed the order and administered the naloxone to R1 who then became responsive and no longer had apnea. RN-A did not find out she had transcribed the order wrong for the naloxone or that she had given the wrong dose, using the wrong type of syringe until the next day. She used 2 -1 ml tuberculin syringes and used the vial of naloxone from the emergency kit, she did not recognize it was only 0.4 mg instead of the 2 mg ordered. RN-A did not order the STAT naloxone from the pharmacy, since this medication was already in the emergency kit, but did not recognize it was the wrong dose.

When interviewed on 7/28/20, at 2:42 p.m. RN-B

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stated HIMS-A requested she review the morphine order for R1 on 7/24/20, and she had done so and approved it. RN-B acknowledged the dosage calculation for the morphine was incorrect, but had not noticed it at the time as, "was most likely between tasks at the time."

When interviewed on 7/29/20, at 10:45 a.m. the director of nursing (DON) stated the dose of naloxone in the emergency kit only contained 0.4 mg/ml and only contained 1 ml, therefore RN-B could not have given the correct dose, and RN-B had stated she used a tuberculin syringe, with a very short needle, which means it could not have been given into a muscle as ordered either. The DON stated they had started to re-train nurses on transcribing physician orders starting on 7/25/20, after the error was discovered. However, the training did not include drug dosage calculations, which was the root cause of the error.

When interviewed on 7/29/20, at 10:21 a.m. the consultant pharmacist (CP)-I stated if the facility needs a medication STAT, they can take the medication from the emergency kit and call the pharmacy to get a delivery at any time of the day or night. The pharmacy is also always available to assist with drug calculations as needed. The naloxone 0.4 mg/ml is a common dose to be used in nursing homes, if the order was for a higher dose, they would have to order the medication STAT.

When interviewed on 7/29/20, at 11:30 a.m. medical director (MD)-A indicated that a normal dose of naloxone to treat a severe opioid overdose would be naloxone 2-4 mg IM. MD-A stated that a dose of 80 mg of morphine, "Would reduce respirations and cause sleepiness and

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lethargy. Theoretically it could end their life." MD-A stated they were in the process of reviewing the dosage of naloxone available in the facilities emergency kit and increasing it to 2 mg. The nurse should have called EMS for support or to get additional naloxone if not able to get the correct dose STAT.

When interviewed on 7/29/20, at 10:47 a.m. hospice nurse, RN-G stated they had arrived at the facility and noted R1 continued to be unresponsive with a respiratory rate of 8 breathes per minute with a repeating pattern of 4 breathes followed by 15 second periods of apnea. RN-G informed RN-E and RN-F to administer any naloxone available in the facility. RN-H returned from the facility assisted living section with a bottle of naloxone 4 mg nasal spray, which was administered and R1 began to respond and apnea ceased.

When interviewed on 7/30/20, at 9:27 a.m. RN-E stated they had come into work on 7/25/20, at 7:45 a.m. and found R1 unresponsive with a respiratory rate of 10. Hospice was contacted and stated RN-G would come to the facility to assess R1. RN-E checked the emergency kit and noted there was one 1 ml vial of naloxone 0.4mg/ml remaining. RN-E discussed with RN-F and called the pharmacy and discovered the pharmacy had never received the order for the naloxone 2 mg STAT. They would fill it ASAP. RN-E stated they decided to await the arrival of the hospice nurse before determining whether to give more naloxone, even though R1 was unresponsive with apnea.

When interviewed on 7/30/20, at 10:12 a.m. RN-F stated, they had assessed R1 on 7/25/20,

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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 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 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 administer each route of medication.

The facility submitted a training entitled Intradermal Injection/Subcutaneous Medication/Intramuscular, and Medication Administration Education, which included medication order processing, which showed facility nurses had been retrained on 7/25/20. However, the training lacked any education

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notification of physician with condition change, monitoring resident's after medication error, calculation drug dosages, or how to choose the appropriate syringe for injections.

The facility Medication Administration Policy dated December 2018, identified accurate transcription of orders is the responsibility of licensed nursing staff. The policy did not indicate other staff who could transcribe medication orders. The policy included, the medication administration record will include the name of the medication, dosage, route, frequency, and any other information including specific monitoring required prior to administration of medication.

The facility Order Processing Policy dated February 2016 indicates that physician medication orders should include time and frequency of the medication and should include the route of administration.

The immediate jeopardy that began on 7/24/20, was removed on 7/30/20, when the facility educated all licensed nurses on dosage calculation, correct syringes and techniques for injectable medications, how to verify orders that are input into the EMR by unlicensed staff, observation of the resident after a medication error/overdose, notification of physician when there is no access to the correct dose of STAT medications and utilization of the EMS system if needed, ordering STAT medications from the pharmacy, and how to recognize an inappropriate dose of medication. In addition, Mollies staff responsible for inputting orders into the EMR were retrained and educated to consult with a nurse when in doubt of an order. The facility also conducted an audit on all liquid medications to

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F 760	Continued From page 14 ensure accuracy in the EMR. Audits were started on all new orders, which were to continue for 14 days and be re-evaluated. All nurses and trained medication aides (TMA's) were audited for medication administration. This was verified by observation, interview and document review by the surveyors on 7/30/20. However, the noncompliance remained at the lower scope and severity level of a G, isolated actual harm that is not immediate jeopardy, because R1 was harmed when she received the incorrect doses of morphine and became unresponsive with respiratory distress, received the wrong dose of the reversal medication and the unresponsive episodes and respiratory distress continued for over 24 hours.	F 760		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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,

Kamala Fiske-Downing

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/28/20 through 7/30/30, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found not to be in compliance with the MN State Licensure. The following complaint found to be SUBSTANTIATED: H5617008C.	2 000		

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error	21545		8/24/20

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21545	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 error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. 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 (IJ) situation for R1 who received a dose of morphine (a narcotic analgesic) sixteen times the dose ordered, resulting in unresponsiveness, hypoxia (low oxygen level) and respiratory distress. The physician ordered a medication to reverse the effects of the morphine overdose, the order was again transcribed incorrectly and a dose was administered to R1 less than what was ordered and via the wrong route of administration. This resulted in drowsiness and intermittent unresponsiveness, hypoxia, and respiratory distress for R1 for over 24 hours. The immediate jeopardy began on 7/24/20, when	21545	Corrected	

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two significant medication errors occurred for R1. The facility administrator, director of nursing (DON) and the facility campus administrator were notified of the immediate jeopardy at 3:51 p.m. on 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.

Findings include:

R1's significant change Minimum Data Set (MDS) dated 7/1/20, included moderate cognitive impairment, required extensive to total assistance with most activities of daily living (ADL's), had pain daily at a level 8 (on a 0-10 scale with 0 being no pain and 10 being excruciating/unmanageable pain), had shortness of breath with exertion, and received an opioid (narcotic) medication 7 out of the 7 day look back period. R1 had diagnoses that included, hip fracture, heart failure, and Alzheimer's disease.

R1's care plan dated 7/15/20, included a recent femur fracture, staff were directed to provide medications as ordered. Hospice care was added to the care plan on 7/20/20 for a diagnosis of Alzheimer's disease.

R1's medication administration record (MAR) dated 7/20/20, included an order for, "Morphine Sulfate (concentrate) Solution 20 MG/ML (milligrams per milliliters) give 0.25 ml [5 mg] by mouth every 4 hours for Pain. DO NOT AWAKE TO GIVE MEDICATION."

R1's Hospice progress note dated 7/24/20, 2:46 p.m. included, "Writer reviewed EHR [electronic health record] and then spoke with facility nurse

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[name of nurse]. She indicated that [R1's name] overall does not look good. She indicated that held 0800 [8:00 a.m.] dose of morphine as patient was asleep. Writer indicated that would remove part of the order that says HOLD IF ASLEEP. Writer instructed [nurse] regarding how to slide syringe inside cheek if asleep, and also giving a PRN [as needed] dose when awakens if scheduled dose held. In this way, will get caught up to base line dose, to manage symptoms. [Nurse] also indicated that patient is eating little. Writer informed her regarding family goal of decreasing Haldol [an antipsychotic medication often used for agitation/hallucinations/delusions when in dying process], but we may need to increase morphine if pain persists at present dose. Family is concerned about her being so sleepy. Writer went to [R1's] room. [R1] was sitting in her Broda Chair [reclining chair] dozing. She did arouse when name was stated. [R1] acknowledged that writer was new; writer explained that patient has always been asleep with [sic] writer came into room. Patient stated, 'I don't feel good.' She could not elaborate on that, and did not reply to questions about pain, writer noted that resps [respiratory] rate was elevated at 28 BPM [breaths per minute/normal is 12-16] Asked patient if was having difficulty catching breath, patient stated yes."

R1's new physician order dated 7/24/20, included, "Morphine 20 mg/ml, give 5 mg po/sl, every 4 hours around the clock." However, the order was transcribed into the electronic medical record (EMR) and the medication administration record (MAR) by health information management specialist (HIMS)-A as, "Morphine sulfate (concentrate) solution 20 MG/ML, give 4 ml [80 mg] by mouth every 4 hours for Pain/Dyspnea, 5 mg = 4 ml." This resulted in the morphine dose

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being 16 times higher than the dose actually ordered by the physician. Registered nurse (RN)-A signed off as double checking the order to ensure accuracy on 7/24/20, at 4:20 p.m.

R1's progress note dated 7/25/20, at 1:44 a.m. and written by RN-A included, "Writer gave 2 separate does of 4 mls of morphine to resident. First dose at 1640 [4:40 p.m.], second dose at 2100 [9:00 p.m.] 8 mls in total given to resident when it should have been 0.5 ml give for entire evening shift. Order was entered incorrectly in PCC [Point Click Care, the facilities EMR]; writer confirmed incorrect order and that is how medication error occurred. 2330 [11:30 p.m.] is when NOC [night] nurse went to go check on resident and found her RR [respiratory rate] 6-8 per minute [normal 12-16], HR [heart rate] 74 [normal 60-100] and 02 sats [oxygen level] 77% [normal 95-100%]. Noc nurse put resident on 2.5 liters of 02 [oxygen] via nasal cannula. Resident 02 went to 90% and later to 98%. Writer called hospice to inform of error and resident condition. Writer corrected error in PCC [the EMR] to reflect correct dosing of 0.25 mls per 4 hours. Writer received order to give 2mg of naloxone [a narcotic reversal medication] STAT [immediately] injection to resident, up to 10 mgs, until rousable and to proceed with 15 minute checks 8 times for 2 hours, then checks every hours for 6 hours. Resident was rousable after one administration. Writer then called POA [power of attorney] about error and resident condition. Resident is currently on 2.5 liters of O2, sats are 97%. RR 16-18 per minute. Pulse 75."

R1's Presbyterian Homes Hospice order dated 7/25/20, at 12:42 a.m. included, "Naloxone 2 mg IM [in the muscle] now- May be repeated every 2-3 minutes, as needed until client is rousable,

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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 to R1. The report 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 muscle as ordered. In addition, the Naloxone had not been ordered from the pharmacy and therefore not available when needed in the morning for R1 when she became unresponsive again with

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21545	Continued From page 8 periods of apnea. R1's progress note dated 7/25/20, 4:08 p.m. included, "7:30 a.m. Night shift reported to writer that resident is arousable and respiration is 16 b/m [breaths per minute]; and response to yes or no questions. 7:45-10:00 a.m. writer took the full set of vital signs; respirations: 8-10 b/m, oxygen saturation: 94% on 2l/min [2 liters per minute] oxygen; BP [blood pressure] 110/70; t-[temperature] 98.2; p-[pulse] 76 b/m [beats per minute]; hospice nurse was informed about the residents ongoing health condition and informed that she did not get the proper dose of naloxone; naloxone was ordered from the pharmacy as a stat [immediate] order however the pharmacy told that it will take 2 hr [hours] for the process and arrival; family members was informed regarding the resident ongoing health condition and and [sic] give the option if she would like to send the resident to the hospital; responsible party told that she would like [sic] rely on the decision of the hospice nurse and would like to meet with the hospice nurse; hospice nurse was informed that family member want to meet the hospice nurse and leave the decision of the resident to the hospice nurse; hospice nurse arrived around 10:20 and family member was informed about the arrival of the nurse." R1's progress note dated 7/25/20, 2:12 p.m. included, 10:30 a.m. "Seen resident not arousable accompanied by hospice nurse; hospice nurse stayed with resident in room; received information that hospice nurse is waiting for family member to come in and make decision if resident will be sent to ER [emergency room] or not." 10:50 a.m. "Resident's POA [power of attorney] arrived; made the decision of not to admit the resident to the hospital and to wait for	21545		

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the Narcan [brand name for naloxone] to be delivered; clinical administrator and clinical administrator [sic] was aware. Writer followed up with pharmacy re: time of arrival of Narcan and pharmacist informed writer that they are processing it and will be sent ASAP."

R1's progress note dated 7/25/20, 11:00 a.m. included, "Writer checked with AL [assisted living] clinical administrator for availability of Narcan in their E-kit; AL clinical administrator informed writer to check their medication room; found Narcan nasal spray in their medication cart, called AL clinical administrator again to inform and gave a go signal to use it if appropriate." "11:05 a.m. Writer approached hospice nurse and asked that since Narcan medication from pharmacy is still not available, if we can use the Narcan Nasal Spray; hospice nurse verbalized, "I will secure the order later for the spray." "11:10 a.m. Hospice nurse administered 4 mg of Narcan Nasal Spray, writer present as witness." "11:25 a.m. Resident became responsive and conversant; accompanied by sister in room." "12:45 p.m. Narcan injection was received from pharmacy; writer verified with hospice nurse if [sic] which form of Narcan (spray or injection) is to be given; hospice nurse confirmed to stick with the using the spray as indicated in the recent orders."

R1's progress note dated 7/25/20, 1:00 p.m. included, "Resident drank approximately 60 cc [cubic centimeters] of apple juice and ate a small portion of the cherry cake as reported by hospice nurse and her sister." 1:30 p.m. "Hospice nurse reported that she increase O2 @ 5 lpm via nasal cannula; resident is resting comfortably, sleepy but she is arousable to speech and touch; able to make short verbal responses." 2:10 p.m.

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21545	Continued From page 10 "Resident is responsive to speech and touch; still accompanied by her sister." R1's progress note dated 7/25/20, 4:00 p.m. included a respiratory rate of 12, oxygen level 90% on oxygen at 5 lpm, and resident was not arousable. 5:40 p.m. unable to open mouth for supper. 6:30 p.m. unable to arouse. 7:30 sleeping, respiratory rate of 12 and oxygen level of 99%. 9:00 p.m. R1 was not arousable. opened one eye during bed bath and made a noise. 10:20 p.m. respirations had dropped to 8 and the Narcan was administered again. 11:00 p.m. unable to arouse and all medications had been held. Although R1 had received doses of Narcan, she continued to have symptoms of respiratory depression and unresponsiveness as a result of the medication error. R1's progress note dated 7/26/20, 7:29 a.m. noted respirations stable through the night, no apnea and did respond verbally when spoken to. When interviewed on 7/28/20, at 2:30 p.m. HIMS-A stated RN-D had written a verbal order for the change in morphine on 7/24/20, HIMS-A transcribed the order into the EMR (Point Click Care). However, the order was written as Morphine 20 mg/ml, 5 mg every 4 hours, there was no milliliter equivalent and the PCC system would not take the order unless there was a milliliter designated for the amount. HIMS-A stated she did the math/drug calculation, by dividing the 20 mg by the 5 mg and came up with 4 milliliters, but was unsure she had calculated this correctly. She had never been trained to calculate drug doses, so she had RN-B review it and RN-B said it was good. She identified it is the facility policy to have a nurse check off on any orders processed by an HIMS, so RN-A signed	21545		

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21545	Continued From page 11 off on the order later in the shift. When interviewed on 7/28/20, at 12:45 p.m. RN-A stated, she had seen the order for R1's morphine in the computer as needing a nurse to sign off on it, she had assumed the dosage calculation had been done correctly and signed off on it without doing the dosage calculation herself. "I just signed what [HIMS-A] had written." RN-A stated she had given R1 the incorrect dose of morphine as it was transcribed, the 4 ml to equal 80 mg twice during her shift, not noting the discrepancy. When the night shift came on duty they did a narcotic count together and the night nurse [RN-D] noted there was too much morphine used and checked on R1 who was unresponsive and having apnea with respirations of only 8 per minute. This was how they found the medication error. She called hospice to report the error and R1's condition. Hospice returned the call and ordered the naloxone, she processed the order and administered the naloxone to R1 who then became responsive and no longer had apnea. RN-A did not find out she had transcribed the order wrong for the naloxone or that she had given the wrong dose, using the wrong type of syringe until the next day. She used 2 -1 ml tuberculin syringes and used the vial of naloxone from the emergency kit, she did not recognize it was only 0.4 mg instead of the 2 mg ordered. RN-A did not order the STAT naloxone from the pharmacy, since this medication was already in the emergency kit, but did not recognize it was the wrong dose. When interviewed on 7/28/20, at 2:42 p.m. RN-B stated HIMS-A requested she review the morphine order for R1 on 7/24/20, and she had done so and approved it. RN-B acknowledged the dosage calculation for the morphine was	21545		

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incorrect, but had not noticed it at the time as, "was most likely between tasks at the time."

When interviewed on 7/29/20, at 10:45 a.m. the director of nursing (DON) stated the dose of naloxone in the emergency kit only contained 0.4 mg/ml and only contained 1 ml, therefore RN-B could not have given the correct dose, and RN-B had stated she used a tuberculin syringe, with a very short needle, which means it could not have been given into a muscle as ordered either.

When interviewed on 7/29/20, at 10:21 a.m. the consultant pharmacist (CP)-I stated if the facility needs a medication STAT, they can take the medication from the emergency kit and call the pharmacy to get a delivery at any time of the day or night. The pharmacy is also always available to assist with drug calculations as needed. The naloxone 0.4 mg/ml is a common dose to be used in nursing homes, if the order was for a higher dose, they would have to order the medication STAT.

When interviewed on 7/29/20, at 11:30 a.m. medical director (MD)-A indicated that a normal dose of naloxone to treat a severe opioid overdose would be naloxone 2-4 mg IM. MD-A stated that a dose of 80 mg of morphine, "Would reduce respirations and cause sleepiness and lethargy. Theoretically it could end their life." MD-A stated they were in the process of reviewing the dosage of naloxone available in the facilities emergency kit and increasing it to 2 mg.

When interviewed on 7/29/20, at 10:47 a.m. hospice nurse, RN-G stated they had arrived at the facility and noted R1 continued to be unresponsive with a respiratory rate of 8 breathes per minute with a repeating pattern of 4 breathes

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	27189	A. BUILDING: _____ B. WING _____	C 07/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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followed by 15 second periods of apnea. RN-G informed RN-E and RN-F to administer any naloxone available in the facility. RN-H returned from the facility assisted living section with a bottle of naloxone 4 mg nasal spray, which was administered and R1 began to respond and apnea ceased.

When interviewed on 7/30/20, at 9:27 a.m. RN-E stated they had come into work on 7/25/20, at 7:45 a.m. and found R1 unresponsive with a respiratory rate of 10. Hospice was contacted and stated RN-G would come to the facility to assess R1. RN-E checked the emergency kit and noted there was one 1 ml vial of naloxone 0.4mg/ml remaining. RN-E discussed with RN-F and called the pharmacy and discovered the pharmacy had never received the order for the naloxone 2 mg STAT. They would fill it ASAP. RN-E stated they decided to await the arrival of the hospice nurse before determining whether to give more naloxone, even though R1 was unresponsive with apnea.

When interviewed on 7/30/20, at 10:12 a.m. RN-F stated, they had assessed R1 on 7/25/20, 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 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

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21545	Continued From page 14 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 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 administer each route of medication. The facility submitted a training entitled Intradermal Injection/Subcutaneous Medication/Intramuscular, and Medication Administration Education, which included medication order processing, which showed facility nurses had been retrained on 7/25/20. However, the training lacked any education notification of physician with condition change, monitoring resident's after medication error, calcuation drug dosages, or how to choose the appropriate syringe for injections. The facility Medication Administration Policy dated December 2018, identified accurate transcription of orders is the responsibility of licensed nursing staff. The policy did not indicate other staff who could transcribe medication orders. The policy included, the medication administration record will include the name of the medication, dosage, route, frequency, and any other information including specific monitoring required prior to administration of medication.	21545		

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21545	Continued From page 15 The facility Order Processing Policy dated February 2016 indicates that physician medication orders should include time and frequency of the medication and should include the route of administration. The immediate jeopardy that began on 7/24/20, was removed on 7/30/20, when the facility educated all licensed nurses on dosage calculation, correct syringes and techniques for injectable medications, how to verify orders that are input into the EMR by unlicensed staff, observation of the resident after a medication error/overdose, notification of physician when there is no access to the correct dose of STAT medications and utilization of the EMS system if needed, ordering STAT medications from the pharmacy, and how to recognize an inappropriate dose of medication. In addition, nonlicensed staff responsible for inputting orders into the EMR were retrained and educated to consult with a nurse when in doubt of an order. The facility also conducted an audit on all liquid medications to ensure accuracy in the EMR. Audits were started on all new orders, which were to continue for 14 days and be re-evaluated. All nurses and trained medication aides (TMA's) were audited for medication administration. This was verified by observation, interview and document review by the surveyors on 7/30/20. However, the noncompliance remained at the lower scope and severity level of a G, isolated actual harm that is not immediate jeopardy, because R1 was harmed when she received the incorrect doses of morphine and became unresponsive with respiratory distress, received the wrong dose of the reversal medication and the unresponsive episodes and respiratory distress continued for over 24 hours.	21545		

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21545	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		