MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Health and Rehab New Brighton

Facility Address:
825 First Avenue NW

Facility City:
New Brighton

State: Minnesota | **ZIP:** 55112 | **County:** Ramsey

Report Number:
H5164121 and H5164124

Date of Visit:
November 28 and 29, 2016

Time of Visit:
9:00 a.m. to 3:30 p.m.
8:00 a.m. to 12:00 p.m.

Date Concluded:
January 8, 2018

Investigator's Name and Title:
Jessica Sellner, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):
It is alleged a resident was neglected when the alleged perpetrator (AP)/staff administered wrong medications to the resident. The resident was transfered to the hospital when emergency medical treatment was required.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) administered incorrect medications to the resident. The resident had decreased responsiveness and required transportation to the hospital by ambulance. The resident was admitted to the hospital for five days with a diagnosis of accidental overdose.

The resident had moderate cognitive impairment and required one staff assistance with all activities of daily living.

On the evening of the incident, a staff member called in sick and the AP was asked to fill in. The AP was not available to start working until two hours after the regular shift was scheduled to start. One and a half hours after the AP administered medication, the resident was difficult to arouse, was drooling, and was acting differently than normal. The AP realized s/he had administered another resident's medication to the resident. The medication administered to the resident was clozapine 400 mg, Lexapro 40 mg, Ativan 1 mg, Singular 10 mg, and Seroquel 50 mg. The AP called for assistance from another staff member, and began to monitor the resident's vital signs and neurological signs. Approximately two hours after the medication error was discovered, staff contacted the physician about the resident's vital signs and neurological checks. The resident's vital signs and neurological checks were within normal limits, and the physician directed staff to push fluids and continue to check vital signs every two hours. The facility staff continued to monitor the

resident's vital signs which continued to be within normal limits until approximately nine hours later. Then, the facility obtained a physician order to send the resident to the emergency room for decreased responsiveness.

The resident went to the hospital by ambulance and was admitted for five days for accidental overdose and a urinary tract infection. The resident was difficult to arouse and not communicating for approximately three days after admission to the hospital. The hospital monitored the residents vital signs, heart rhythm, and provided intravenous fluids when the resident was unable to eat or drink the first three days due to the unresponsiveness. The resident was discharged from the hospital and did not return to the facility. The resident's cognition returned to baseline; however, the resident was weak and required increased staff assistance with transfers.

The resident was discharged from the facility at the time of the on-site investigation and was not interviewed.

During an interview, the AP admitted to administering the incorrect medications to the resident. The AP stated s/he was called into work that evening to fill in for an employee sick call. The AP stated s/he told the facility s/he would arrive at the facility about two hours late for the shift, and s/he requested specifically not to be assigned to the unit the resident was on due to the number of treatments and blood sugar checks. The facility told the AP s/he had to work on the unit, because the staff in the other unit were not trained on the medication cart. The AP stated s/he arrived that evening two hours after the shift began because the facility called and needed staff on short notice. The AP stated the medication pass, which was scheduled to be completed prior to the evening meal was not started, and s/he was behind on medications, treatments, and blood sugar checks from the beginning of the shift. The AP stated earlier that day s/he had expressed his/her concerns to management including feeling overwhelmed with the amount of work duties to be completed. While completing the evening medication pass, the AP had been interrupted often by other residents, staff, and phone calls.

The facility suspended the AP, provided re-education and observed her/his medication administration prior to allowing her/him to return to work. Medication audits were performed by the facility on all nursing staff.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility failed to provide adequate staffing levels to prevent the medication error. The facility also failed to provide adequate training to staff working on the medication carts.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes

- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Call Light Audits
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Seven

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Discharged

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ◉ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:
03/22/2017	1:40 p.m.	04/19/2017	9:30 a.m.	05/11/2017	12:20 p.m.

Interview with family: ○ Yes ◉ No ○ N/A Specify: Unable to contact

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Discharged

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Six

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour
☒ Other: Medication Storage

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

New Brighton Police Department

Ramsey County Attorney

New Brighton City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 7, 2017

Mr. Kurtis Rollin, Administrator
Health And Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

****AMENDED LETTER: This letter redacts and replaces the letter dated March 27, 2017.****

RE: Project Number H5164121 & H5164124

Dear Mr. Rollin:

On March 2, 2017, and in our revised letter of March 13, 2017,we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 7. (42 CFR 488.422)

Additionally, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty of for the deficiency cited at F333. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 22, 2017 that included an investigation of complaint numbers H5164121 & H5164124. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on February 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our complaint investigation, completed on February 22, 2017, as of March 15, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 15, 2017.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	R-C 03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON OPCO LLC	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(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 ****REVISED**** A Post Certification revisit was conducted on 3/20/17, to follow up on deficiencies issued related to complaint #H5164121 and H5164124. Health and Rehab New Brighton is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically Signed | 03/30/2017

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 7, 2017

Mr. Kurtis Rollin, Administrator
Health And Rehabilitation of New Brighton
825 First Avenue Northwest
New Brighton, MN 55112

****AMENDED LETTER: This letter redacts and replaces the letter dated March 27, 2017.****

Re: Enclosed Reinspection Results - Complaint Number H5164121 & H5164124

Dear Mr. Rollin:

On March 20, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on February 22, 2017. At this time these correction orders were found corrected.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00114	A. BUILDING: _____ B. WING _____	R-C 03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON OPCO LLC	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: ****REVISED**** A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5164121 and H5164124. Health and Rehab New Brighton was found in compliance with state regulations.	{2 000}		

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

Electronically Signed — 03/30/17

Minnesota Department of Health

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	00114	A. BUILDING: _____ B. WING _____	R-C 03/20/2017

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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 the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245164	A. BUILDING _____ B. WING _____	C 02/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 000	INITIAL COMMENTS ****REVISED**** An abbreviated standard survey was conducted to investigate case #H5164121 and H5164124. As a result, the following deficiency is issued related to case #H5164121 and H5164124. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 7 residents reviewed, R1, who were administered another residents medication. This resulted in actual harm for R1 when the resident had a decrease in consciousness, drop in blood pressure, and was admitted to the hospital. Findings include: R1's admission Minimum Data Set (MDS) dated 11/14/16, indicated the resident had moderate cognitive impairment, and required extensive assistance with all activities of daily living. A Physician Telephone Order dated 11/1/16, at	F 333	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regualtory requirements. R1 is no longer a resident at Health and Rehabilitation of New Brighton Residents at Health and Rehabilitation for New Brighton who receive medication administration from license nursing staff could be affected by this practice.	3/15/17

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

Electronically Signed | 03/13/2017

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 1 10:00 p.m. directed staff to monitor R1's vital signs and do neuro checks every 30 minutes for two hours, and to call the physician at midnight with an update. A Physician Telephone order dated 11/2/16, at 12:30 a.m. directed staff to push fluids and obtain vital signs on R1 every two hours overnight. A Physician Telephone order dated 11/2/16, at 9:40 a.m. directed staff to send R1 to the emergency room for increased sleepiness related to medication intoxication. R1's Progress Note dated 11/2/16, titled IDT (interdisciplinary team) review, indicated the resident was sent to the hospital due to increased sleepiness, decreased blood pressure, and increased congestion. R1's hospital emergency room notes dated 11/2/16, indicated the resident was being admitted for accidental overdose. The resident was given another residents medications, which were Clozapine 400 mg (milligrams), Lexapro 20 mg, Lorazepam 1 mg, Singulair 10 mg, Seroquel 50 mg, and Pepcid 20 mg. When EMS (emergency medical services) arrived at the facility, the facility stated the resident was found earlier in the morning with vomit on her mouth and pillow. R1 was minimally responsive when EMS arrived at the facility and had been that way in the ambulance during transport to the hospital. R1 was admitted to the hospital for unintentional antipsychotic overdose, and urinary tract infection. The resident discharged from the hospital on 11/7/16, five days later, to another facility.	F 333	Licensed nursing staff/Certified TMA's are educated upon hire/annually/PRN on facility medication administration policies and procedures. Licensed/certified staff were re-educated on facility medication administration to include but not limited to 2 resident identifiers utilized when administering medications following the even on 11/02/16 by DON/Designee. Immediate Action: LPN-H was issued disciplinary action at a "Final Discharge Warning" and immediately suspended pending an internal investigation. LPN-H was assigned medication adminstration re-education which was completed prior to her return to work from suspention and a medical leave on January 19, 2017. Immediate Intervention: Facility Nurse Educator performed audits of medication administration best practice. 10 nurses were audited over 2 shifts for medication administration best practice. Facility Nurse Educator noted zero occurances of medication errors that resulted in or would have resulted in resident harm. DON/Designee will audit nursing staff on medication administration with resident medication pass to ensure compliance with facility medication administration policies and procedures x3 audits weekly per shift for one month abd then x1 audit weekly per shift for two additional months. Audit results will be reviewed at monthly QAPI meetings x 3 months to ensure	

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F 333	Continued From page 2 When interviewed on 11/29/16, at 8:20 a.m. staffing coordinator (SC)-F stated on 11/1/16, the facility called licensed practical nurse (LPN)-H to see if she was able to come in and work to replace a sick call from another nurse. SC-F stated LPN-H agreed to come in for the evening shift, however, she would not be able to come in to start the shift until about 4:30 p.m.- 5:00 p.m. so the day nurse stayed until LPN-H arrived. When interviewed on 11/29/16, at 9:05 a.m. LPN-G stated he was the other nurse on the unit with LPN-H on the evening shift on 11/1/16. LPN-G administered medications on the unit on medication cart 1, and LPN-H administered the medications on the unit on medication cart 2. LPN-G stated LPN-H requested assistance with obtaining resident blood sugars due to starting the shift late as blood sugars and medications were not completed prior to LPN-H arriving. LPN-G stated on 11/1/16, at approximately 8:30 p.m. LPN-H asked for assistance because she felt, "something was wrong," with R1. LPN-G stated when assessing R1 the resident was weak, confused, and drooling out of the left side of her mouth. LPN-G stated after assessing the resident LPN-H stated she may have given R1 the wrong medications earlier in the shift. LPN-G called the physician regarding R1's status and received orders to monitor the resident and update the physician at midnight. During interview on 11/29/16, at 9:05 a.m. director of nursing (DON) stated LPN-H was called on 11/1/16, to work the evening shift. DON stated LPN-H was able to come in but was not going to arrive until about 4:30 p.m.- 5:00 p.m. DON stated the day nurse agreed to stay until LPN-H arrived. DON stated LPN-H was passing	F 333	consistent implementation of the facility's medication admistration policy and procedures.	

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HEALTH AND REHABILITATION OF NEW BRIGHTON	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 333	Continued From page 3 medications and was also the house supervisor the evening of 11/1/16. DON stated LPN-H had called her on 11/1/16, at home around 6:00 p.m. to discuss a insulin dosing question. During the phone call LPN-H told DON that she was behind in passing medications, treatments, blood sugar checks, and insulin's because she had started the shift late. DON stated she asked LPN-H if there was anything she needed, and LPN-H told her there was nothing specific she needed. During interview on 1/17/17, at 1:45 p.m. LPN-H stated the facility called her on 11/1/16, at 3:08 p.m. to work the evening shift. LPN-H stated she arrived at the facility approximately 4:30 p.m. When she arrived the 4:00 p.m. medications were not completed and there were approximately 8-9 resident blood sugars that needed to be checked prior to supper. LPN-H stated that at approximately 5:30 p.m. she felt so overwhelmed she went to check the schedule to request assistance from the nurse supervisor. However, when she checked the schedule she discovered she was the nurse supervisor. LPN-H stated she had multiple physician orders that needed to be entered, several phone calls that needed to be made, a sick call for the night shift she needed to replace, residents requesting assistance to go to activities, and she had started out behind on medications and treatments. LPN-H stated at approximately 9:30 p.m. on 11/1/16, R1 was laying in bed and, "was not herself." LPN-H stated R1 was difficult to arouse, and was drooling. LPN-H stated when observing R1 she realized she may have administered the wrong medication to the resident about one hour prior. LPN-H stated she had been interrupted by so many phone calls, resident requests, starting the shift out behind, and was the house supervisor	F 333		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 02/22/2017

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F 333	Continued From page 4 that she prepared another residents medication and walked into R1's room and administered the wrong medications to R1. The facility policy and procedure procedure titled Medication Administration dated 3/2016, directed staff to check the following when administering medication(s): Right medication, right dose, right dosage form, right route, right resident, right time. The policy further directs staff to explain the procedure to the resident and include the type of medication ordered, the reason, frequency, and route.	F 333		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: ****REVISED**** A complaint investigation was conducted to investigate complaint #H5164121 and H5164124. As a result, the following correction orders are issued related to #H5164121 and H5164124. The facility has agreed to participate in the electronic	2 000		

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2 000	Continued From page 1 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 electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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		
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	21545		3/15/17

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21545	Continued From page 2 be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the 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 interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 7 residents reviewed, R1, who were administered another residents medication. This resulted in actual harm for R1 when the resident had a decrease in consciousness, drop in blood pressure, and was admitted to the hospital. Findings include: R1's admission Minimum Data Set (MDS) dated 11/14/16, indicated the resident had moderate cognitive impairment, and required extensive	21545	Corrected	

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21545	Continued From page 3 assistance with all activities of daily living. A Physician Telephone Order dated 11/1/16, at 10:00 p.m. directed staff to monitor R1's vital signs and do neuro checks every 30 minutes for two hours, and to call the physician at midnight with an update. A Physician Telephone order dated 11/2/16, at 12:30 a.m. directed staff to push fluids and obtain vital signs on R1 every two hours overnight. A Physician Telephone order dated 11/2/16, at 9:40 a.m. directed staff to send R1 to the emergency room for increased sleepiness related to medication intoxication. R1's Progress Note dated 11/2/16, titled IDT (interdisciplinary team) review, indicated the resident was sent to the hospital due to increased sleepiness, decreased blood pressure, and increased congestion. R1's hospital emergency room notes dated 11/2/16, indicated the resident was being admitted for accidental overdose. The resident was given another residents medications, which were Clozapine 400 mg (milligrams), Lexapro 20 mg, Lorazepam 1 mg, Singulair 10 mg, Seroquel 50 mg, and Pepcid 20 mg. When EMS (emergency medical services) arrived at the facility, the facility stated the resident was found earlier in the morning with vomit on her mouth and pillow. R1 was minimally responsive when EMS arrived at the facility and had been that way in the ambulance during transport to the hospital. R1 was admitted to the hospital for unintentional antipsychotic overdose, and urinary tract infection. The resident discharged from the hospital on 11/7/16, five days later, to another	21545		

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21545	Continued From page 4 facility. When interviewed on 11/29/16, at 8:20 a.m. staffing coordinator (SC)-F stated on 11/1/16, the facility called licensed practical nurse (LPN)-H to see if she was able to come in and work to replace a sick call from another nurse. SC-F stated LPN-H agreed to come in for the evening shift, however, she would not be able to come in to start the shift until about 4:30 p.m.- 5:00 p.m. so the day nurse stayed until LPN-H arrived. When interviewed on 11/29/16, at 9:05 a.m. LPN-G stated he was the other nurse on the unit with LPN-H on the evening shift on 11/1/16. LPN-G administered medications on the unit on medication cart 1, and LPN-H administered the medications on the unit on medication cart 2. LPN-G stated LPN-H requested assistance with obtaining resident blood sugars due to starting the shift late as blood sugars and medications were not completed prior to LPN-H arriving. LPN-G stated on 11/1/16, at approximately 8:30 p.m. LPN-H asked for assistance because she felt, "something was wrong," with R1. LPN-G stated when assessing R1 the resident was weak, confused, and drooling out of the left side of her mouth. LPN-G stated after assessing the resident LPN-H stated she may have given R1 the wrong medications earlier in the shift. LPN-G called the physician regarding R1's status and received orders to monitor the resident and update the physician at midnight. During interview on 11/29/16, at 9:05 a.m. director of nursing (DON) stated LPN-H was called on 11/1/16, to work the evening shift. DON stated LPN-H was able to come in but was not going to arrive until about 4:30 p.m.- 5:00 p.m. DON stated the day nurse agreed to stay until LPN-H	21545		

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21545	Continued From page 5 arrived. DON stated LPN-H was passing medications and was also the house supervisor the evening of 11/1/16. DON stated LPN-H had called her 11/1/16, at home around 6:00 p.m. to discuss a insulin dosing question. During the phone call LPN-H told DON that she was behind in passing medications, treatments, blood sugar checks, and insulin's because she had started the shift late. DON stated she asked LPN-H if there was anything she needed, and LPN-H told her there was nothing specific she needed. During interview on 1/17/17, at 1:45 p.m. LPN-H stated the facility called her on 11/1/16, at 3:08 p.m. to work the evening shift. LPN-H stated she arrived at the facility approximately 4:30 p.m. When she arrived the 4:00 p.m. medications were not completed and there were approximately 8-9 resident blood sugars that needed to be checked prior to supper. LPN-H stated that at approximately 5:30 p.m. she felt so overwhelmed she went to check the schedule to request assistance from the nurse supervisor. However, when she checked the schedule she discovered she was the nurse supervisor. LPN-H stated she had multiple physician orders that needed to be entered, several phone calls that needed to be made, a sick call for the night shift she needed to replace, residents requesting assistance to go to activities, and she had started out behind on medications and treatments. LPN-H stated at approximately 9:30 p.m. on 11/1/16, R1 was laying in bed and, "was not herself." LPN-H stated R1 was difficult to arouse, and was drooling. LPN-H stated when observing R1 she realized she may have administered the wrong medication to the resident about one hour prior. LPN-H stated she had been interrupted by so many phone calls, resident requests, starting the shift out behind, and was the house supervisor	21545		

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21545	Continued From page 6 that she prepared another residents medication and walked into R1's room and administered the wrong medications to R1. The facility policy and procedure procedure titled Medication Administration dated 3/2016, directed staff to check the following when administering medication(s): Right medication, right dose, right dosage form, right route, right resident, right time. The policy further directs staff to explain the procedure to the resident and include the type of medication ordered, the reason, frequency, and route. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review medication administration policy and procedures with all staff. Director of nursing or designess could monitor staff to ensure medication administration is completed according to facility policy and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as	21850		3/15/17

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21850	Continued From page 7 authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 7 residents, R1, was free from maltreatment when the resident was administered another residents medication. This resulted in actual harm for R1 when the resident had a decrease in consciousness, drop in blood pressure, and was admitted to the hospital. Findings include: R1's admission Minimum Data Set (MDS) dated 11/14/16, indicated the resident had moderate cognitive impairment, and required extensive assistance with all activities of daily living. A Physician Telephone Order dated 11/1/16, at 10:00 p.m. directed staff to monitor R1's vital signs and do neuro checks every 30 minutes for two hours, and to call the physician at midnight with an update. A Physician Telephone order dated 11/2/16, at 12:30 a.m. directed staff to push fluids and obtain vital signs on R1 every two hours overnight. A Physician Telephone order dated 11/2/16, at 9:40 a.m. directed staff to send R1 to the emergency room for increased sleepiness related to medication intoxication. R1's Progress Note dated 11/2/16, titled IDT (interdisciplinary team) review, indicated the	21850	Corrected	

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21850	Continued From page 8 resident was sent to the hospital due to increased sleepiness, decreased blood pressure, and increased congestion. R1's hospital emergency room notes dated 11/2/16, indicated the resident was being admitted for accidental overdose. The resident was given another residents medications, which were Clozapine 400 mg (milligrams), Lexapro 20 mg, Lorazepam 1 mg, Singulair 10 mg, Seroquel 50 mg, and Pepcid 20 mg. When EMS (emergency medical services) arrived at the facility, the facility stated the resident was found earlier in the morning with vomit on her mouth and pillow. R1 was minimally responsive when EMS arrived at the facility and had been that way in the ambulance during transport to the hospital. R1 was admitted to the hospital for unintentional antipsychotic overdose, and urinary tract infection. The resident discharged from the hospital on 11/7/16, five days later, to another facility. When interviewed on 11/29/16, at 8:20 a.m. staffing coordinator (SC)-F stated on 11/1/16, the facility called licensed practical nurse (LPN)-H to see if she was able to come in and work to replace a sick call from another nurse. SC-F stated LPN-H agreed to come in for the evening shift, however, she would not be able to come in to start the shift until about 4:30 p.m.- 5:00 p.m. so the day nurse stayed until LPN-H arrived. When interviewed on 11/29/16, at 9:05 a.m. LPN-G stated he was the other nurse on the unit with LPN-H on the evening shift on 11/1/16. LPN-G administered medications on the unit on medication cart 1, and LPN-H administered the medications on the unit on medication cart 2. LPN-G stated LPN-H requested assistance with	21850		

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21850	Continued From page 9 obtaining resident blood sugars due to starting the shift late as blood sugars and medications were not completed prior to LPN-H arriving. LPN-G stated on 11/1/16, at approximately 8:30 p.m. LPN-H asked for assistance because she felt, "something was wrong," with R1. LPN-G stated when assessing R1 the resident was weak, confused, and drooling out of the left side of her mouth. LPN-G stated after assessing the resident LPN-H stated she may have given R1 the wrong medications earlier in the shift. LPN-G called the physician regarding R1's status and received orders to monitor the resident and update the physician at midnight. During interview on 11/29/16, at 9:05 a.m. director of nursing (DON) stated LPN-H was called on 11/1/16, to work the evening shift. DON stated LPN-H was able to come in but was not going to arrive until about 4:30 p.m.- 5:00 p.m. DON stated the day nurse agreed to stay until LPN-H arrived. DON stated LPN-H was passing medications and was also the house supervisor the evening of 11/1/16. DON stated LPN-H had called her 11/1/16, at home around 6:00 p.m. to discuss a insulin dosing question. During the phone call LPN-H told DON that she was behind in passing medications, treatments, blood sugar checks, and insulin's because she had started the shift late. DON stated she asked LPN-H if there was anything she needed, and LPN-H told her there was nothing specific she needed. During interview on 1/17/17, at 1:45 p.m. LPN-H stated the facility called her on 11/1/16, at 3:08 p.m. to work the evening shift. LPN-H stated she arrived at the facility approximately 4:30 p.m. When she arrived the 4:00 p.m. medications were not completed and there were approximately 8-9 resident blood sugars that needed to be checked	21850		

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21850	Continued From page 10 prior to supper. LPN-H stated that at approximately 5:30 p.m. she felt so overwhelmed she went to check the schedule to request assistance from the nurse supervisor. However, when she checked the schedule she discovered she was the nurse supervisor. LPN-H stated she had multiple physician orders that needed to be entered, several phone calls that needed to be made, a sick call for the night shift she needed to replace, residents requesting assistance to go to activities, and she had started out behind on medications and treatments. LPN-H stated at approximately 9:30 p.m. on 11/1/16, R1 was laying in bed and, "was not herself." LPN-H stated R1 was difficult to arouse, and was drooling. LPN-H stated when observing R1 she realized she may have administered the wrong medication to the resident about one hour prior. LPN-H stated she had been interrupted by so many phone calls, resident requests, starting the shift out behind, and was the house supervisor that she prepared another residents medication and walked into R1's room and administered the wrong medications to R1. The facility policy and procedure procedure titled Medication Administration dated 3/2016, directed staff to check the following when administering medication(s): Right medication, right dose, right dosage form, right route, right resident, right time. The policy further directs staff to explain the procedure to the resident and include the type of medication ordered, the reason, frequency, and route. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review medication administration policy and procedures with all staff. Director of nursing or designess could monitor staff to ensure medication	21850		

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HEALTH AND REHABILITATION OF NEW BRIG	825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112

(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
21850	Continued From page 11 administration is completed according to facility policy and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		