

## Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Health and Rehab New Brighton		Report Number: H5164121 and H5164124	Date of Visit: November 28 and - 29, 2016		
Facility Address: 825 First Avenue N Facility City:			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	
New Brighton			Investigator's Name and Title:		
State: Minnesota	<b>ZIP:</b> 55112	County: Ramsev	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 transferred to the hospital when emergency medical treatment was required.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- |x| 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

Facility Name: Health and Rehab New Brighton

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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 Vulnerab	le Adults Act (Minnesota Statu	ites, section 626.557)			
Under the Minnesota	Vulnerable Adults Act (Minn	esota Statutes, section 626.557):			
☐ Abuse	Neglect     Neglect	☐ Financial Exploitation			
Substantiated     Sub	☐ Not Substantiated	☐ Inconclusive based on the following information:			
	ors" in Minnesota Statutes, sec ☐ Individual(s) and/or ☑ Fa	tion 626.557, subdivision 9c (c) were considered and it was cility is responsible for the			

☐ Abuse 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. □ No State licensing orders were issued: x Yes (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. □ No X Yes State licensing orders were issued: (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: ☐ No **x** Yes (State licensing orders will be available on the MDH website.) Compliance Notes: **Facility Corrective Action:** The facility took the following corrective action(s):

Facility Name: Health and Rehab New Brighton

Report Number: H5164121 and H5164124

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Facility Name: Health and Rehab New Brighton

#### **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:

- Medical Records
- X Care Guide
- ▼ Medication Administration Records
- Nurses Notes
- **X** Assessments
- Physician Orders
- **X** Treatment Sheets
- Physician Progress Notes

Care Plan Records Social Service Notes Skin Assessments X **x** Facility Incident Reports ■ Laboratory and X-ray Reports Therapy and/or Ancillary Services Records X ADL (Activities of Daily Living) Flow Sheets Other pertinent medical records: X Ambulance/Paramedics **Hospital Records** Additional facility records: Resident/Family Council Minutes Staff Time Sheets, Schedules, etc. ▼ Facility Internal Investigation Reports Call Light Audits Personnel Records/Background Check, etc. Facility In-service Records Facility Policies and Procedures Number of additional resident(s) reviewed: Seven  $\bigcirc$  N/A Were residents selected based on the allegation(s)?  $\bigcirc$  No Yes Specify: Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?  $\bigcirc$  N/A No Yes Specify: Discharged Interviews: The following interviews were conducted during the investigation: Interview with complainant(s) O Yes No  $\bigcirc$  N/A If unable to contact complainant, attempts were made on: Time: Time: Date: Date: Time: Date: 12:20 p.m. 05/11/2017 9:30 a.m. 04/19/2017 03/22/2017 1:40 p.m. ○ N/A Specify: Unable to contact Interview with family: O Yes No Did you interview the resident(s) identified in allegation:

Facility Name: Health and Rehab New Brighton

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Facility Name: Health and Rehab New Brighton

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○ Ye	es	Specify: Discharge esidents? • Yes	O No		
	I number of resident inte		_		
	view with staff:   Yes	$\bigcirc$ No $\bigcirc$ N/A	Specify:		
mici	View with stan.				1
	iessen Warnings				
	essen Warning given as I		○ No		
Tota	I number of staff intervie	ews: Eight			
Phys	ician Interviewed: 🔘 Ye				
	e Practitioner Interviewe				
	ician Assistant Interview			0 10	
Inter	rview with Alleged Perpe	trator(s):	○ No ○ N/A	Specify:	
Atte	mpts to contact:			5.1.	Timo
Date	e: Time:	Date:	Time:	Date:	Time:
					∩ No
	nable to contact was subp	ooena issued: 🔘 Ye	es, date subpoena w	/as issued	
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Report Number: H5164121 and H5164124

Facility Name: Health and Rehab New Brighton

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

**New Brighton City Attorney** 

**Ramsey County Attorney** 



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.

Health And Rehabilitation of New Brighton September 7, 2017 Page 2

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



cc: Licensing and Certification File

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

PRINTED: 02/06/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  NEW BRIGHTON OPCO LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST  NEW BRIGHTON, MN 55f12  SUMMARY SYSTEMENT OF DEFICIENCIES NEW BRIGHTON, MN 55f12  PREFIX FROUDERS PLAN OF CORRECTION REQUILATORY OR LSC IDENTIFYING INFORMATION)  (F 000)  INITIAL COMMENTS  ****REVISED****  A Post Certification revisit was conducted on 3/20/17, to follow up on deficiencies issued related to complaint #H5f164/121 and H5f64/124. 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.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  NEW BRIGHTON OPCO LLC  (XA) ID  SEJAMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)  (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.				A. BOILE	,,,,			l l
NEW BRIGHTON OPCO LLC    X   D   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)   PREFIX TAGK   TAGK   D   PREFIX TAGK   PRE			245164	B. WING			03/2	20/2017
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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.		****REVISED****						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		3/20/17, to follow u related to complain Health and Rehab with 42 CFR Part 4 for Long Term Care  The facility is enrol signature is not recapage of the CMS-2 correction is require	p on deficiencies issued It #H5164121 and H5164124. New Brighton is in compliance 83, subpart B, requirements in Example Facilities.  It is required and therefore a puired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility					
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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.

03/30/2017

**Electronically Signed** 



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



cc: Licensing and Certification File

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING 03/20/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST **NEW BRIGHTON OPCO LLC NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {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.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

STATION BINESTONS ON THE STATE OF THE STATE

TITLE

(X6) DATE 03/30/17

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_ R-C B. WING\_ 03/20/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST **NEW BRIGHTON OPCO LLC NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) {2 000} {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.

Minnesota Department of Health STATE FORM

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

PRINTED: 09/15/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		"	
		245164	B. WING	·		l	22/2017
	PROVIDER OR SUPPLIER  AND REHABILITATION	ON OF NEW BRIGHTON		82	REET ADDRESS, CITY, STATE, ZIP CODE 25 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
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	harm for R1 when	on. This resulted in actual the resident had a decrease in op in blood pressure, and was spital.			set forth on the survey report. Our correction is prepared and execute means to continuously improve the of care and to comply with all appl state and federal regualtory require	ed as a e quality icable ements.	
	R1's admission Mi 11/14/16, indicated cognitive impairme assistance with all	inimum Data Set (MDS) dated d the resident had moderate ent, and required extensive activities of daily living.			R1 is no longer a resident at Healt Rehabilitation of New Brighton  Residents at Health and Rehabilitation who receive medicate administration from license nursing could be affected by this practice.	ation for tion	
L	LA TARREST OF PROVI	IDED/SLIDDLIED DEDDESENTATIVE'S SIG	MATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

03/13/2017

**Electronically Signed** 

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.

Facility ID: 00114

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

PRINTED: 09/15/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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HEALTH A	ND REHABILITATION	ON OF NEW BRIGHTON		N	EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
	signs and do neur two hours, and to with an update.  A Physician Teleph 12:30 a.m. directed vital signs on R1 of A Physician Teleph 9:40 a.m. directed emergency room to medication into R1's Progress No (interdisciplinary to resident was sent sleepiness, decreding increased congest R1's hospital ementing admitted for accident was given anothed were Clozapine 4 mg, Lorazepam 150 mg, and Pepc (emergency med facility, the facility earlier in the morand pillow. R1 w EMS arrived at the in the ambulance R1 was admitted antipsychotic over infection. The resident was respectively and pillow. R1 was admitted antipsychotic over infection. The resident was resident was admitted antipsychotic over infection. The resident was admitted antipsychotic over infection.	d staff to monitor R1's vital o checks every 30 minutes for call the physician at midnight hone order dated 11/2/16, at exercise to be supported as and obtain every two hours overnight.  The hone order dated 11/2/16, at a staff to send R1 to the for increased sleepiness related xication.  The dated 11/2/16, titled IDT eam) review, indicated the to the hospital due to increased ased blood pressure, and		333	Licensed nursing staff/Certified Treducated upon hire/annually/PRN facility medication administration and procedures. Licensed/certifie were re-educated on facility mediadministration to include but not 12 resident identifiers utilized wher administering medications followieven on 11/02/16 by DON/Design Immediate Action: LPN-H was issed disciplinary action at a "Final Disciplinary action at a "Final Disciplinary and immediately suspepending an internal investigation. was assigned medication administreducation which was completed her return to work from suspention medical leave on January 19, 20.  Immediate Intervention: Facility Neducator performed audits of meadministration best practice. To readministration best practice. Factor Nurse Educator noted zero occumedication errors that resulted in have resulted in resident harm.  DON/Designee will audit nursing medication administration with remedication pass to ensure composite that the sulter in the sulter of the policies and procedures x3 audit per shift for one month abd then weekly per shift for two additions.  Audit results will be reviewed at QAPI meetings x 3 months to ensure composition.	on policies d staff cation imited to n ng the nee. sued charge nded LPN-H stration ed prior to on and a 17.  Jurse dication nurses dication ility rances of n or would staff on esident bliance ation s weekly x1 audit al months monthly	

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

PRINTED: 09/15/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245164	B. WING			1	2/2017
	PROVIDER OR SUPPLIE  AND REHABILITAT	R ION OF NEW BRIGHTON		82	TREET ADDRESS, CITY, STATE, ZIP CODE 25 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	staffing coordinate facility called lice see if she was alto replace a sick castated LPN-H ag shift, however, shift of start the shift is so the day nurse. When interviewed LPN-G stated hewith LPN-H on the LPN-G administer medications on the LPN-G stated LF obtaining resident the shift late as the were not compled LPN-G stated or p.m. LPN-H asked felt, "something stated when ass weak, confused, of her mouth. Little resident LPN-H the wrong medicalled the physic received orders update the physic received orders update the physic received the physic received orders update the phy	d on 11/29/16, at 8:20 a.m. for (SC)-F stated on 11/1/16, the need practical nurse (LPN)-H to ble to come in and work to all from another nurse. SC-F reed to come in for the evening ne would not be able to come in antil about 4:30 p.m 5:00 p.m. stayed until LPN-H arrived.  If on 11/29/16, at 9:05 a.m. was the other nurse on the unit are evening shift on 11/1/16. Freed medications on the unit on 1, and LPN-H administered the he unit on medication cart 2. PN-H requested assistance with a blood sugars and medications ted prior to LPN-H arriving.  In 11/1/16, at approximately 8:30 red for assistance because she was wrong," with R1. LPN-G resting R1 the resident was and drooling out of the left side PN-G stated after assessing the stated she may have given R1 regarding R1's status and to monitor the resident and ician at midnight.		3333	consistent implementation of the famedication admistration policy and procedures.	acility's	
	of nursing (DON 11/1/16, to work LPN-H was able arrive until abou stated the day n	on 11/29/16, at 9:05 a.m. director b) stated LPN-H was called on the evening shift. DON stated to come in but was not going to t 4:30 p.m 5:00 p.m. DON urse agreed to stay until LPN-H tated LPN-H was passing					

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

PRINTED: 09/15/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN (	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION	COMPLETED	
		245164	B. WING	i			22/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
		ON OF NEW BRIGHTON			25 FIRST AVENUE NORTHWEST EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 333	medications and with evening of 11/1 called her on 11/1 to discuss a insuli phone call LPN-H in passing medicatchecks, and insulishift late. DON st was anything she there was nothing.  During interview of stated the facility p.m. to work the earrived at the facility p.m. to work the facility p.m. to supper. Lapproximately 5:3 she went to check she was the nurshad multiple physically p.m. to work the facility p.m. to	vas also the house supervisor 1/16. DON stated LPN-H had /16, at home around 6:00 p.m. n dosing question. During the told DON that she was behind ations, treatments, blood sugar in's because she had started the rated she asked LPN-H if there needed, and LPN-H told her pecific she needed.  on 1/17/17, at 1:45 p.m. LPN-H called her on 11/1/16, at 3:08 evening shift. LPN-H stated she lity approximately 4:30 p.m. If the 4:00 p.m. medications were dithere were approximately 8-9 gars that needed to be checked LPN-H stated that at 30 p.m. she felt so overwhelmed is the schedule to request the nurse supervisor. However, and the schedule she discovered e supervisor. LPN-H stated she sician orders that needed to be for the night shift she needed to be for the night shift she needed to be a requesting assistance to go to be had started out behind on treatments. LPN-H stated at 30 p.m. on 11/1/16, R1 was 1, "was not herself." LPN-H fficult to arouse, and was stated when observing R1 she of have administered the wrong the resident about one hour prior. The had been interrupted by so so the had been interrupted by so so the had been interrupted by so so the had started she house supervisor.		333			

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

PRINTED: 09/15/2017 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING	COV	(X3) DATE SURVEY COMPLETED C	
		245164	B. WING			/22/2017	
	F PROVIDER OR SUPPLIE TH AND REHABILITAT	R TION OF NEW BRIGHTON		STREET ADDRESS, CITY, STATE, ZIF 825 FIRST AVENUE NORTHWES NEW BRIGHTON, MN 55112	Т		
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F 33	and walked into I wrong medication  The facility policy Medication Admi staff to check the medication(s): F dosage form, rig The policy further procedure to the	d another residents medication R1's room and administered the		333			

Minneso	ta Department of He	ealth		<u></u>		0.5.5.5	OUD /C\
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	inco.	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	IDER.	A. BUILDING: _			
						C	
		00114		B. WING		02/2	2/2017
NAMEOF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
					ORTHWEST		
HEALTH	AND REHABILITATIO	ON OF NEW BRIG	NEW BRIG	HTON, MN	55112	OTION	(VE)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDI	ER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deputermination of water corrected requires requirements of the number and MN R When a rule contact comply with any of lack of compliance re-inspection with a result in the assess	Minnesota Statute, section order has been itele. If, upon reinspection of deficiencies dected, a fine for each be assessed in accordines promulgated by partment of Health.  Whether a violation has compliance with all e rule provided at the ule number indicated ins several items, failuite items will be consecuted in the items will be consecuted in the items of multi-part is ment of a fine even it during the initial inspection.	issued on, it is cited violation dance rule of been tag below. ure to sidered upon rule will f the item				
	You may request a that may result from orders provided the the Department with notice of assessministral COMMEN	a hearing on any asses m non-compliance wit at a written request is ithin 15 days of receip ent for non-complianc	th these made to t of a				
Minnesota I	investigate compla As a result, the fol issued related to # facility has agreed	igation was conducted aint #H5164121 and H lowing correction order #H5164121 and H5164121	I5164124. ers are 4124. The lectronic		TITLE		(X6) DATE

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

03/13/17

Electronically Signed

Minnesot	a Department of He	ealth			O(O) DATE (	NIDVEV
STATEMEN'	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	Contonicon	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
					С	
		00114	B. WING		02/22	2/2017
			DDRESS, CITY, S	TATE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER					
HEALTH.	AND REHABILITATIO		ST AVENUE N IGHTON, MN			
	CLIMMADV ST/	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	, ,,, ,, ,	
2 000	Continued From pa	age 1	2 000			
*	receipt of State lice	ensure orders consistent with				
	the Minnesota Dep	partment of Health				
	Informational Bulle	tin 14-01, available at	_			
	http://www.health.s	state.mn.us/divs/fpc/profinfo/in				
	obul.htm The Sta	te licensing orders are				
	delineated on the a	attached Minnesota				
	Department of Hea	alth orders being submitted nough no plan of correction is				:
:	necessary for State	e Statutes/Rules, please enter				
	the word "corrected	d" in the box available for text.				
	Then indicate in th	e electronic State licensure				
	process, under the	heading completion date, the				
	date your orders w	vill be corrected prior to				
		nitting to the Minnesota				
	Department of Hea	aith.				
21545	MN Rule 4658.132	20 A.B.C Medication Errors	21545			3/15/17
	A nursing home m	ust ensure that:				
	A. Its medicat	ion error rate is less than five				
	percent as describ	ped in the Interpretive				
	Guidelines for Cod	de of Federal Regulations, title	•			
	42, section 483.25	(m), found in Appendix P of				
	the State Operation	ons Manual, Guidance to g-Term Care Facilities, which i	g			
	incorporated by re	eference in part 4658.1315. Fo	or l			
	purposes of this p	art, a medication error means	:			
ĺ	(1) a discrepa	ancy between what was				
	prescribed and wh	nat medications are actually				
	administered to re	esidents in the nursing home; o	r			
	, ,	nistration of expired				
	medications.	any significant medication				
	error A significan	nt medication error is:				
	(1) an error	r which causes the resident				
	discomfort or jeop	pardizes the resident's health o	r			
	safety: or					
	(2) medica	tion from a category that usua	ly			
	requires the medi	cation in the resident's blood to	,			

	ta Department of He		T area saus Fibra	= CONCERNATION	(X3) DATE SURVE	·V
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	COMPLETED	. '
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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		00114	B. WING		02/22/201	7
			DRESS CITY S	STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	=	•			Ì
HFA! TH	AND REHABILITATION	NI OE NEW PDIG	ST AVENUE N			
HEALIN		NEW DIG	GHTON, MN		211	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL		X5) PLETE
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		ATE
TAG	REGULATORTORE	DENTI THE IN STANKING	,,,,	DEFICIENCY)		
			04545			
21545	Continued From pa	age 2	21545			
	he titrated to a spe	cific blood level and a single				
	medication error co	ould alter that level and				
	precipitate a reocci	urrence of symptoms or				
	toxicity. All medical	tions are administered as				
	prescribed. An inc	cident report or medication				
	error report must b	e filed for any medication error				
	that occurs. Any s	ignificant medication errors or				
	resident reactions	must be reported to the				
	physician or the ph	ysician's designee and the				
	resident or the resi	ident's legal guardian or	1			
	designated represe	entative and an explanation				
		ne resident's clinical record.				
		ions are administered as	_			
	prescribed. An inc	cident report or medication erro	r			
	report must be file	d for any medication error that				
	occurs. Any signif	icant medication errors or	0			
	resident reactions	must be reported to the				
	physician or the ph	hysician's designee and the				
	resident or the res	ident's legal guardian or		,		
	designated repres	entative and an explanation				
	must be made in the	he resident's clinical record.				
	This MNI Requirem	nent is not met as evidenced				
	by:	TOTAL TO THOU AND OVIGORIOUS				
	Based on interview	v and record review, the facility		Corrected		
	failed to ensure re	sidents were free from				
	significant medica	tion errors for 1 of 7 residents				
	reviewed R1 who	were administered another				
	residents medicati	ion. This resulted in actual				
	harm for R1 when	the resident had a decrease ir	ı			
		op in blood pressure, and was				
	admitted to the ho	spital.				
		1				
	Findings include:					
	R1's admission M	inimum Data Set (MDS) dated				
	11/14/16, indicated	d the resident had moderate				
	cognitive impairme	ent, and required extensive				

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 02/22/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST HEALTH AND REHABILITATION OF NEW BRIG **NEW BRIGHTON, MN 55112** (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21545 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

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_ С 02/22/2017 B. WING 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST HEALTH AND REHABILITATION OF NEW BRIG **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21545 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

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ С 02/22/2017 B WING 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST **HEALTH AND REHABILITATION OF NEW BRIG NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21545 Continued From page 5 21545 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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00114		B. WING		02/22/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
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
21545	Continued From page 6		21545			
	that she prepared another residents medication and walked into R1's room and administered the wrong medications to R1.					
	Medication Adminis staff to check the formedication(s): Rig dosage form, right The policy further of procedure to the re	and procedure procedure titled stration dated 3/2016, directed ollowing when administering the medication, right dose, right route, right resident, right time. Ilirects staff to explain the sident and include the type of I, the reason, frequency, and				
	The director of nurs medication adminis with all staff. Direc could monitor staff	THOD OF CORRECTION: sing or designee, could review stration policy and procedures tor of nursing or designess to ensure medication empleted according to facility res.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21850	MN St. Statute 144 Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850			3/15/17
	Residents shall be defined in the Vulni "Maltreatment" me section 626.5572, intentional and non physical pain or injuconduct intended to distress. Every resident in the properties of the street of t	om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the -therapeutic infliction of ury, or any persistent course of o produce mental or emotional sident shall also be free from emical and physical restraints, imented emergencies, or as			,	

Minnesota Department of Health STATE FORM

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: С B. WING\_ 02/22/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST HEALTH AND REHABILITATION OF NEW BRIG **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 7 21850 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 Based on interview and record review, the facility Corrected 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

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: С B. WING 02/22/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST HEALTH AND REHABILITATION OF NEW BRIG **NEW BRIGHTON, MN 55112** (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 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 wav 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

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medications on the unit on medication cart 2. LPN-G stated LPN-H requested assistance with

PRINTED: 09/15/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 02/22/2017 00114 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST **HEALTH AND REHABILITATION OF NEW BRIG NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 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

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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

PRINTED: 09/15/2017 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 00114 02/22/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 FIRST AVENUE NORTHWEST **HEALTH AND REHABILITATION OF NEW BRIG NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 10 21850 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.

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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

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_ C B. WING \_ 02/22/2017 00114 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FIRST AVENUE NORTHWEST **HEALTH AND REHABILITATION OF NEW BRIG NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 11 administration is completed according to facility policy and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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