Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
North Ridge Health and Rehabilitation	H5183141 and H5183142	April 6, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
5430 Boone Avenue North	9:30 a.m. to 6:30 p.m.	December 18, 2017
Facility City:	**Investigator's Name and Title:**	
New Hope	Arthur Biah, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55428	Hennepin

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when a staff/alleged perpetrator (AP) administered a higher than ordered dose of a narcotic, the resident was found on the floor, paramedic responded and found the resident dead.

☒ 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 preponderance of evidence, neglect occurred when the alleged perpetrator (AP) administered a dose of opioid pain medication that was 20 times the prescribed dose. The facility did not have a system to identify changes in the administration of high-risk medications. The resident died of an oxycodone overdose.

The resident was admitted to the facility for short-term rehabilitation with diagnoses of cancer, chronic pain, and chronic obstructive pulmonary disease. The resident had a physician order for liquid oxycodone with instructions to administer 20 milligrams (mg) for pain rated five to seven on a ten-point scale, or 30 mg for pain rated eight to ten. The concentration of the prescribed oxycodone had fluctuated frequently.

The nurse practitioner first ordered the resident's oxycodone liquid with a concentration of 5 mg/5 milliliters (ml). Five days later, the nurse practitioner changed the concentration of oxycodone to 20 mg/1 ml. Two weeks later, the nurse practitioner changed the oxycodone concentration back to 5 mg/5 ml. Three weeks after this change, the nurse practitioner again changed the oxycodone concentration to 20 mg/1 ml. The dosage of the oxycodone liquid remained the same as 20 mg for pain rated five to seven and 30 mg for pain rated eight to ten throughout the concentration change. The facility did not have a policy and procedure for medication change by a provider or pharmacy with potential risk of resident harm.

On the evening shift before the resident's death, the resident requested oxycodone for pain and rated his/her pain at a ten on the ten-point scale. The narcotic record indicated the AP administered 600 mg (30 ml) of liquid oxycodone from the prescribed 20 mg/ml instead of the 30 mg (1.5 ml) ordered. At the end of the AP's shift, the AP asked the morning nurse supervisor to reorder the resident's oxycodone, because the pharmacy had sent a single dose on the night shift. The nurse supervisor called the pharmacy and confirmed the pharmacy had sent three-day supply of oxycodone and not a one-day supply.

Both the AP and the nurse supervisor went to the resident's room, found the resident on the floor, facing the room entrance. The resident was unresponsive. The AP called 911, and had another staff bring the automatic external defibrillator (AED). The nurse supervisor started cardiopulmonary resuscitation (CPR) and applied the AED. The resident had no heart rhythm. The resident's code status was identified as "limited", meaning no chest compression should be administered, but caregivers could perform manual breathing. The staff stopped CPR and continued to administer oxygen with a manual breathing bag until the ambulance arrived.

During an interview, the AP admitted s/he administered 30 ml of oxycodone via the resident's gastronomy tube. The AP stated s/he did not verify the concentration and dose of the oxycodone administered, because she was busy with multiple patients. The AP stated s/he thought the oxycodone dose was the same as the one s/he administered the last time s/he worked with the resident. The AP stated s/he did not follow her training and the facility's policy on medication administration.

The emergency medical services (EMS) run sheet indicated the EMS staff applied an electrocardiogram and noted no heart rhythm in three leads. The EMS determined the resident was deceased given the lack of heartbeat and respiration and the stiffness of the resident's body.

The resident's death certificate indicated the resident's immediate cause of death as oxycodone toxicity.

During an interview, the resident's nurse practitioner verified the resident's oxycodone concentration was changed frequently. The nurse practitioner stated changing between different concentrations increased the risk of error in administration.

When interviewed, the medical director stated based on his/her professional experience and opinion, the 600 mg (30 ml) of oxycodone administered to the resident, instead of the prescribed 30 mg (1.5 ml) was responsible for the resident's death. The medical director stated changing between different concentrations increased the risk of error in administration.

After the incident, facility records indicated staff were re-educated on medication administration policy. The facility also indicated the medical director and pharmacy were working to revise ways to notify nurses when medication dosages are changed.

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 did not have a policy to notify staff of changing medication orders with potential for resident harm. The AP did not follow facility policy and procedure of medication administration, administered opioid medication to the resident without verifying the right dose and failed to follow a physician's order in medication administration.

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:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

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 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.

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
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes

☒ Physician Orders
☒ Physician Progress Notes
☒ Care Plan Records
☒ Facility Incident Reports

Other pertinent medical records:

☒ Ambulance/Paramedics ☒ Death Certificate

Additional facility records:

☒ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

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: Deceased

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:

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

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

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

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

☒ Medication Pass

☒ Cleanliness

☒ Safety Issues

☒ Facility Tour

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

Minnesota Board of Pharmacy

The Office of Ombudsman for Long-Term Care

New Hope Police Department

New Hope City Attorney

Hennepin County Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 20, 2017

Ms. Diane Willette, Administrator
North Ridge Health And Rehabiltation
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Numbers H5183141, H5183142

Dear Ms. Willette:

On July 11, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 16, 2017. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on June 19, 2017. 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 August 23, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on June 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 19, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on June 19, 2017 as of June 19, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 23, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of July 11, 2017:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	R-C 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 A Post Certification revisit was conducted on August 23, 2017, to follow up on deficiencies issued relate to complaint H5183141 and H5183142. North Ridge Health and Rehabilitation Center 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

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 20, 2017

Ms. Diane Willette, Administrator
North Ridge Health And Rehabilitation
5430 Boone Avenue North
New Hope, MN 55428

Re: Reinspection Results - Project Numbers H5183141, H5183142

Dear Ms. Willette:

On August 23, 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 June 19, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	R-C 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5183141 and H5183142. North Ridge Health and Rehab was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	R-C 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 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}		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 11, 2017

Ms. Kristina Guindon, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Numbers H5183141, H5183142

Dear Ms. Guindon:

On June 19, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the attached CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective July 16, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Office of Health Facility Complaints staff if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 19, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 19, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 06/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 An abbreviated standard survey was conducted to investigate case #H5183141 and #H5183142. As a result, the following deficiency is issued. 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	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a resident was free of significant medication error for one of four residents (R1) reviewed, when the resident was administered a higher than ordered dose of Oxycodone. The resident was found dead hours later. Findings include: R1's medical record was reviewed. R1's was admitted to the facility for short term rehabilitation while undergoing chemotherapy and radiation. R1's diagnoses included tongue cancer, chronic pain, and chronic obstructive pulmonary disease. R1 ambulated independently, was alert, oriented and able to make needs known to staff.	F 333		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 06/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 333	Continued From page 1 R1's nurse practitioner orders dated February 16, 2017 was reviewed and indicated an order of Oxycodone 5 milligrams (mg)/5 milliliters (ml) to give 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated February 21, 2017 was reviewed and indicated the Oxycodone concentration was changed to 20 mg/1 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 6, 2017 was reviewed and indicated the Oxycodone concentration was changed to 5 mg/5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 30, 2017 was reviewed and indicated the Oxycodone concentration was changed to 10 mg/0.5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's narcotic record dated April 2, 2017 indicated LPN-H administered 30 ml of the prescribed Oxycodone 10 mg/0.5 ml labeled 20 mg/1 ml to R1 at 2:00 a.m. Nursing progress note dated April 2, 2017 indicated R1 requested Oxycodone and rated the pain at 10 on a zero to ten scale around 2:00 a.m. The note indicated LPN-H administered 30 ml of Oxycodone to R1. LPN-H indicated she checked on R1 around 4:00 a.m. and R1 appeared to be	F 333		

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F 333	Continued From page 2	F 333		

sleeping. At the end of her shift, LPN-H asked the supervisor, registered nurse (RN)-F, to re-order R1's Oxycodone because the nurse gave the one delivered as a single dose. After RN-F confirmed the dose of the Oxycodone delivered from the pharmacy, he instructed LPN-H to check on R1 because the pharmacy has sent a three-day supply and not an one-day supply.

Nursing progress note dated April 2, 2017 indicated R1 was found unresponsive on the floor in R1's room around 7:25 a.m. RN-F asked LPN-H to call the emergency medical services. RN-F rolled R1 on the back and started chest cardiopulmonary resuscitation (CPR). RN-F clarified R1's code status as no CPR and CPR was aborted, but R1 continued received oxygen until EMS arrived and took over.

LPN-D was interviewed on April 6, 2017 at 2:20 p.m. and stated she was assigned to R1 on the evening shift before the incident. LPN-D stated R1 requested Oxycodone for pain at bedtime. LPN-D stated she noted R1 was out of the Oxycodone and she called the pharmacy to send R1's supply of Oxycodone. LPN-D stated she reported to LPN-D the pharmacy was to deliver R1's Oxycodone later that night.

RN-F was interviewed on April 6, 2017 at 2:49 p.m. and stated LPN-H asked him to re-order R1's Oxycodone because the pharmacy sent a single dose on the prior shift. RN-F stated he called the pharmacy and confirmed the pharmacy had sent three-day-supply of Oxycodone instead of one-day supply as reported LPN-H. RN-E stated LPN-H verified the bottle of the Oxycodone that she administered to the resident. RN-F asked LPN-H to check on the resident because

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F 333	Continued From page 3 LPN-H gave a higher than ordered dose of the Oxycodone to R1. Both LPN-H and RN-F went to the R1's room, found R1 on the floor, lying on the left side, and facing the entrance. RN-F stated he asked LPN-H to call the emergency medical services (EMS) and have another staff bring the automatic external defibrillator (AED). RN-F started cardiopulmonary resuscitation (CPR). Staff brought and applied AED with no heart rhythm noted. RN-E was notified of the resident's code status as "limited", meaning no chest compression but ok for manual breathing. RN-E stopped the CPR, but continued administering oxygen with manual breathing bag until EMS arrived. LPN-H was interviewed on April 7, 2017 at 4:30 p.m. and stated s/he was assigned to R1 on the night shift. LPN-H stated R1 requested Oxycodone for pain. LPN-H stated she administered 30 mls of the Oxycodone received from the pharmacy. LPN-H stated she did not verify the concentration and dose of the Oxycodone administered because she was very busy with multiple patients. LPN-H stated she knew, as a licensed nurse, she was supposed to check the dose and order of the Oxycodone prior to administration. LPN-H stated the resident's previous order was for 5 mg/5 ml Oxycodone, not 10 mg/0.5 ml. LPN-H acknowledged she did not follow the facility's policy on medication administration. When asked if LPN-H reassessed R1 after Oxycodone administration, she stated she did not. LPN-H stated she relied on the nurse aide to check on R1 during rounds. The director of nursing was interviewed on April 7, 2017 at 5:29 p.m. and stated the facility is working with its medical director and the	F 333		

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F 333	Continued From page 4	F 333		

pharmacy to change how pharmacy communicates dose/concentration change with staff.

The facility's medical director was interviewed on May 2, 2017 at 8:26 a.m. and stated he reviewed and signed medication administration policy at the facility. The medical director stated he was notified that LPN-H administered 30 ml of Oxycodone to R1. The medical director confirmed the equivalence of 30 ml of 20 mg/1 ml of Oxycodone is 600 mg. The medical director stated, based on his professional experience and opinion, the 30 ml of Oxycodone administered instead of the prescribed 1.5 ml (30 mg) was responsible for R1's death. The medical director also stated the change of concentrations of R1's Oxycodone played a role in the medication error.

R1's nurse practitioner (NP) was interviewed on May 3, 2017 at 12:54 p.m. and stated R1's Oxycodone was changed from less concentration to more concentration. The NP confirmed he ordered the Oxycodone concentrations: 5mg/5ml on February 16, 2017; 20mg/1ml on February 21, 2017; 5mg/5ml on March 6, 2017; and 10mg/0.5ml on March 30, 2017. The NP acknowledged changing concentrations of the same orders increased the risk of medication error.

Facility's record review indicated staff were re-educated on April 2, 2017 medication administration policy and the rights of medication administration (right patient, right medication, right dose, right route, right time, right documentation, right reason, and right response) at every opportunity of medication administration. The facility also indicated the medical director

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F 333	Continued From page 5 and pharmacy were working on a policy and procdure to improve the way of nurses are notified when a medication dosage was changed. The facility indicated the notification process of dosage change would be monitored by audit of medication dosage changes received from the pharmacy. The facility's policy and procedure titled Administering Medications, dated April 2010, indicated medication must administered in accordance with the orders. The policy and procedure also stated the administering staff must check the label three times to verify, among other things, the right medication and right dosage.	F 333		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 11, 2017

Ms. Kristina Guindon, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: Enclosed State Nursing Home Licensing Orders - Complaint Numbers H5183141, H5183142

Dear Ms. Guindon:

A complaint investigation was completed on June 19, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

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

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

If you have questions or concerns you may call me at the number below.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 06/19/2017

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NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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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: A complaint investigation was conducted to investigate complaint #H5183141 and #H5183142. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin	2 000		

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2 000	Continued From page 1 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 be titrated to a specific blood level and a single medication error could alter that level and	21545		

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21545	Continued From page 2 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 interviews and record review, the facility failed to ensure a resident was free of significant medication error for one of four residents (R1) reviewed, when the resident was administered a higher than ordered dose of Oxycodone. The resident was found dead hours later. Findings include: R1's medical record was reviewed. R1's was admitted to the facility for short term rehabilitation while undergoing chemotherapy and radiation. R1's diagnoses included tongue cancer, chronic pain, and chronic obstructive pulmonary disease. R1 ambulated independently, was alert, oriented	21545		

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21545	Continued From page 3 and able to make needs known to staff. R1's nurse practitioner orders dated February 16, 2017 was reviewed and indicated an order of Oxycodone 5 milligrams (mg)/5 milliliters (ml) to give 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated February 21, 2017 was reviewed and indicated the Oxycodone concentration was changed to 20 mg/1 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 6, 2017 was reviewed and indicated the Oxycodone concentration was changed to 5 mg/5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 30, 2017 was reviewed and indicated the Oxycodone concentration was changed to 10 mg/0.5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's narcotic record dated April 2, 2017 indicated LPN-H administered 30 ml of the prescribed Oxycodone 10 mg/0.5 ml labeled 20 mg/1 ml to R1 at 2:00 a.m. Nursing progress note dated April 2, 2017 indicated R1 requested Oxycodone and rated the pain at 10 on a zero to ten scale around 2:00 a.m. The note indicated LPN-H administered 30 ml of Oxycodone to R1. LPN-H indicated she checked	21545		

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21545	Continued From page 4 on R1 around 4:00 a.m. and R1 appeared to be sleeping. At the end of her shift, LPN-H asked the supervisor, registered nurse (RN)-F, to re-order R1's Oxycodone because the nurse gave the one delivered as a single dose. After RN-F confirmed the dose of the Oxycodone delivered from the pharmacy, he instructed LPN-H to check on R1 because the pharmacy has sent a three-day supply and not an one-day supply. Nursing progress note dated April 2, 2017 indicated R1 was found unresponsive on the floor in R1's room around 7:25 a.m. RN-F asked LPN-H to call the emergency medical services. RN-F rolled R1 on the back and started chest cardiopulmonary resuscitation (CPR). RN-F clarified R1's code status as no CPR and CPR was aborted, but R1 continued received oxygen until EMS arrived and took over. LPN-D was interviewed on April 6, 2017 at 2:20 p.m. and stated she was assigned to R1 on the evening shift before the incident. LPN-D stated R1 requested Oxycodone for pain at bedtime. LPN-D stated she noted R1 was out of the Oxycodone and she called the pharmacy to send R1's supply of Oxycodone. LPN-D stated she reported to LPN-D the pharmacy was to deliver R1's Oxycodone later that night. RN-F was interviewed on April 6, 2017 at 2:49 p.m. and stated LPN-H asked him to re-order R1's Oxycodone because the pharmacy sent a single dose on the prior shift. RN-F stated he called the pharmacy and confirmed the pharmacy had sent three-day-supply of Oxycodone instead of one-day supply as reported LPN-H. RN-E stated LPN-H verified the bottle of the Oxycodone that she administered to the resident. RN-F asked LPN-H to check on the resident because	21545		

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21545	Continued From page 5 LPN-H gave a higher than ordered dose of the Oxycodone to R1. Both LPN-H and RN-F went to the R1's room, found R1 on the floor, lying on the left side, and facing the entrance. RN-F stated he asked LPN-H to call the emergency medical services (EMS) and have another staff bring the automatic external defibrillator (AED). RN-F started cardiopulmonary resuscitation (CPR). Staff brought and applied AED with no heart rhythm noted. RN-E was notified of the resident's code status as "limited", meaning no chest compression but ok for manual breathing. RN-E stopped the CPR, but continued administering oxygen with manual breathing bag until EMS arrived. LPN-H was interviewed on April 7, 2017 at 4:30 p.m. and stated s/he was assigned to R1 on the night shift. LPN-H stated R1 requested Oxycodone for pain. LPN-H stated she administered 30 mls of the Oxycodone received from the pharmacy. LPN-H stated she did not verify the concentration and dose of the Oxycodone administered because she was very busy with multiple patients. LPN-H stated she knew, as a licensed nurse, she was supposed to check the dose and order of the Oxycodone prior to administration. LPN-H stated the resident's previous order was for 5 mg/5 ml Oxycodone, not 10 mg/0.5 ml. LPN-H acknowledged she did not follow the facility's policy on medication administration. When asked if LPN-H reassessed R1 after Oxycodone administration, she stated she did not. LPN-H stated she relied on the nurse aide to check on R1 during rounds. The director of nursing was interviewed on April 7, 2017 at 5:29 p.m. and stated the facility is working with its medical director and the pharmacy to change how pharmacy	21545		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 6 communicates dose/concentration change with staff. The facility's medical director was interviewed on May 2, 2017 at 8:26 a.m. and stated he reviewed and signed medication administration policy at the facility. The medical director stated he was notified that LPN-H administered 30 ml of Oxycodone to R1. The medical director confirmed the equivalence of 30 ml of 20 mg/1 ml of Oxycodone is 600 mg. The medical director stated, based on his professional experience and opinion, the 30 ml of Oxycodone administered instead of the prescribed 1.5 ml (30 mg) was responsible for R1's death. The medical director also stated the change of concentrations of R1's Oxycodone played a role in the medication error. R1's nurse practitioner (NP) was interviewed on May 3, 2017 at 12:54 p.m. and stated R1's Oxycodone was changed from less concentration to more concentration. The NP confirmed he ordered the Oxycodone concentrations: 5mg/5ml on February 16, 2017; 20mg/1ml on February 21, 2017; 5mg/5ml on March 6, 2017; and 10mg/0.5ml on March 30, 2017. The NP acknowledged changing concentrations of the same orders increased the risk of medication error. Facility's record review indicated staff were re-educated on April 2, 2017 on the medication administration policy and the rights of medication administration (right patient, right medication, right dose, right route, right time, right documentation, right reason, and right response) at every opportunity of medication administration. The facility also indicated the medical director and pharmacy were working on a policy and procdure to improve the way of nurses are	21545		

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	00238	A. BUILDING: _____ B. WING _____	C 06/19/2017

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21545	Continued From page 7 notified when a medication dosage was changed. The facility indicated the notification process of dosage change would be monitored by audit of medication dosage changes received from the pharmacy. The facility's policy and procedure titled Administering Medications, dated April 2010, indicated medication must administered in accordance with the orders. The policy and procedure also stated the administering staff must check the label three times to verify, among other things, the right medication and right dosage. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. 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 authorized in writing after examination by a	21850		

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21850	Continued From page 8 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 interviews and record review, the facility failed to ensure a resident was free from neglect for one of four residents (R1) reviewed, a resident was administered a higher than ordered dose of Oxycodone. The resident was found dead hours later. Findings include: The facility policy and procedure titled Abuse Prevention Program, revised November 2016 indicated residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, exploitation and involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical condition. The facility policy and procedure titled Administering Medications, dated April 2010, indicated medication must administered in accordance with the orders. The policy and procedure also stated the administering staff must check the label three times to verify, among other things, the right medication and right dosage. R1's medical record was reviewed. R1's was admitted to the facility for short term rehabilitation while undergoing chemotherapy and radiation. R1's diagnoses included tongue cancer, chronic pain, and chronic obstructive pulmonary disease. R1 ambulated independently, was alert, oriented	21850		

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21850	Continued From page 9 and able to make needs known to staff. R1's nurse practitioner orders dated February 16, 2017 was reviewed and indicated an order of Oxycodone 5 milligrams (mg)/5 milliliters (ml) to give 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated February 21, 2017 was reviewed and indicated the Oxycodone concentration was changed to 20 mg/1 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 6, 2017 was reviewed and indicated the Oxycodone concentration was changed to 5 mg/5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's nurse practitioner orders dated March 30, 2017 was reviewed and indicated the Oxycodone concentration was changed to 10 mg/0.5 ml with same dosage of 20 mg every four hour as needed for pain rated five to seven and 30 mg for pain rated eight to ten. R1's narcotic record dated April 2, 2017 indicated LPN-H administered 30 ml of the prescribed Oxycodone 10 mg/0.5 ml labeled 20 mg/1 ml to R1 at 2:00 a.m. Nursing progress note dated April 2, 2017 indicated R1 requested Oxycodone and rated the pain at 10 on a zero to ten scale around 2:00 a.m. The note indicated LPN-H administered 30 ml of Oxycodone to R1. LPN-H indicated she checked	21850		

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21850	Continued From page 10 on R1 around 4:00 a.m. and R1 appeared to be sleeping. At the end of her shift, LPN-H asked the supervisor, registered nurse (RN)-F, to re-order R1's Oxycodone because the nurse gave the one delivered as a single dose. After RN-F confirmed the dose of the Oxycodone delivered from the pharmacy, he instructed LPN-H to check on R1 because the pharmacy has sent a three-day supply and not an one-day supply. Nursing progress note dated April 2, 2017 indicated R1 was found unresponsive on the floor in R1's room around 7:25 a.m. RN-F asked LPN-H to call the emergency medical services. RN-F rolled R1 on the back and started chest cardiopulmonary resuscitation (CPR). RN-F clarified R1's code status as no CPR and CPR was aborted, but R1 continued received oxygen until EMS arrived and took over. LPN-D was interviewed on April 6, 2017 at 2:20 p.m. and stated she was assigned to R1 on the evening shift before the incident. LPN-D stated R1 requested Oxycodone for pain at bedtime. LPN-D stated she noted R1 was out of the Oxycodone and she called the pharmacy to send R1's supply of Oxycodone. LPN-D stated she reported to LPN-D the pharmacy was to deliver R1's Oxycodone later that night. RN-F was interviewed on April 6, 2017 at 2:49 p.m. and stated LPN-H asked him to re-order R1's Oxycodone because the pharmacy sent a single dose on the prior shift. RN-F stated he called the pharmacy and confirmed the pharmacy had sent three-supply of Oxycodone instead of one-day supply as reported LPN-H. RN-E stated LPN-H verified the bottle of the Oxycodone that she administered to the resident. RN-F asked LPN-H to check on the resident because LPN-H	21850		

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21850	Continued From page 11 gave a higher than ordered dose of the Oxycodone to R1. Both LPN-H and RN-F went to the R1's room, found R1 on the floor, lying on the left side, and facing the entrance. RN-F stated he asked LPN-H to call the emergency medical services (EMS) and have another staff bring the automatic external defibrillator (AED). RN-F started cardiopulmonary resuscitation (CPR). Staff brought and applied AED with no heart rhythm noted. RN-E was notified of the resident's code status as "limited", meaning no chest compression but ok for manual breathing. RN-E stopped the CPR, but continued administering oxygen with manual breathing bag until EMS arrived. LPN-H was interviewed on April 7, 2017 at 4:30 p.m. and stated s/he was assigned to R1 on the night shift. LPN-H stated R1 requested Oxycodone for pain. LPN-H stated she administered 30 mls of the Oxycodone received from the pharmacy. LPN-H stated she did not verify the concentration and dose of the Oxycodone administered because she was very busy with multiple patients. LPN-H stated she knew, as a licensed nurse, she was supposed to check the dose and order of the Oxycodone prior to administration. LPN-H stated the resident's previous order was for 5 mg/5 ml Oxycodone, not 10 mg/0.5 ml. LPN-H acknowledged she did not follow the facility's policy on medication administration. When asked if LPN-H reassessed R1 after Oxycodone administration, she stated she did not. LPN-H stated she relied on the nurse aide to check on R1 during rounds. The facility's medical director was interviewed on May 2, 2017 at 8:26 a.m. and stated he reviewed and signed medication administration policy at the facility. The medical director stated he was	21850		

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21850	Continued From page 12 notified that LPN-H administered 30 ml of Oxycodone to R1. The medical director confirmed the equivalence of 30 ml of 20 mg/1 ml of Oxycodone is 600 mg. The medical director stated, based on his professional experience and opinion, the 30 ml of Oxycodone administered instead of the prescribed 1.5 ml (30 mg) was responsible for R1's death. The medical director also stated the change of concentrations of R1's Oxycodone played a role in the medication error. R1's nurse practitioner (NP) was interviewed on May 3, 2017 at 12:54 p.m. and stated R1's Oxycodone was changed from less concentration to more concentration. The NP confirmed he ordered the Oxycodone concentrations: 5mg/5ml on February 16, 2017; 20mg/1ml on February 21, 2017; 5mg/5ml on March 6, 2017; and 10mg/0.5ml on March 30, 2017. The NP acknowledged changing concentrations of the same orders increased the risk of medication error.The facility's policy and procedure titled Abuse Prevention Program dated November 2016 indicated residents have the right to be free from neglect. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		