Electronically delivered

April 12, 2019

Administrator
The Emeralds at St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

Re: Reinspection Results - Project Numbers S5295029, H5295141, H5295148, H5295149, H5295155C, H5295159C, H5295161C, H5295151, H5295153C, H5295156C, H5295157C, H5295158C, H5295160C

Dear Administrator:

On February 26, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2019. 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 14, 2019

Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders - Complaint Number H5295148, H5295149, H5295155C, H5295159C, H5295161C, H5295151, H5295153C, H5295156C, H5295157C, H5295158C, H5295160C,

Dear Administrator:

A complaint investigation was completed on January 24, 2019. 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, 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 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:

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(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 on January 22, 23 and 24, 2019, to investigate complaints H5295154C, H5295149, H5295151, H5295153C, H5295155C, H5295156C, H5295157C, H5295158C, H5295159C, H5295160C and H5295161C. Bethel Care Center IS NOT in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities for F585, F610 and G760. Complaint H5295154C was substantiated at F760 Complaint H5295149 was substantiated at F760 Complaint H5295155C was substantiated at F760 Complaint H5295159C was substantiated at F760 Complaint H5295161C was substantiated at F610 Complaint H5295151 was not substantiated. Compliant H5295153C was not substantiated. Complaint H5295156C was not substantiated. Complaint H5295157C was not substantiated. Complaint H5295158C was not substantiated. Complaint H5295160C was not substantiated. The facility is enrolled in the electronic Plan of Correction (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 you acknowledge receipt of the electronic documents.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		2/20/19

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

Electronically Signed | 02/18/2019

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F 610	Continued From page 1 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to thoroughly investigate and respond to an allegation of abuse, and maintain documentation of the investigation, which had the potential to affect 1 of 4 residents (R47) reviewed who were involved in allegations of resident-to-resident abuse. Findings include: Review of a Nursing Home Incident Report submitted 12/29/18, revealed an allegation on 12/29/18, stating R37 touched R47's breast after R47 asked R37 for a hug. When interviewed shortly after the incident, R47 did not think it was a "big deal", and did not think R37 knew what he was doing. Review of the investigation summary submitted 1/4/19, revealed the action taken to prevent reoccurrence was to educate R47 not to ask for hugs from other residents, as it put R47 at risk for inappropriate touching from others. Review of internal investigation documents on file from the allegation did not include documentation	F 610	F 610 D Investigate/Prevent/Correct Alleged Violation Immediate corrective action: Immediate education was held on 1/23/2019 with the ID Team on conducting a thorough investigation to include interviews of other residents and staff. No further issues have been reported involving resident #37. Resident #47 re-interviewed to assure no further concerns. Action as it applies to others: The Abuse Prevention Plan and Policy for Resident to Resident Abuse Policy was reviewed and remains current. Education with all staff on conducting thorough investigations, to include Reporting to MDH, Risk Management, interviewing other residents and staff, initiating new interventions, updating Care Plan and alerting staff of any changes, and informing Administrator/Designee, MD and Resident Representative. Date of completion: 2/20/2019	

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F 610	Continued From page 2 of interviews with staff and other residents. Review of the minimum data set (MDS) assessment dated 12/14/18, revealed R37 had a BIMS (brief interview for mental status) score of 14, indicating R37 was cognitively intact. Review of the MDS assessment dated 12/21/18, revealed R47 had a BIMS score of 15, indicating R47 was cognitively intact. During observation of the unit on 1/23/19, R37's room was observed to be across the hall from R47's room. During interview on 1/23/19, at 11:04 a.m. R47 confirmed being touched inappropriately by R37. She described sitting at a table in the dining room in front of the television when R37 pulled up next to her in a wheelchair. R47 described always being cordial with R37, and said R37 had always been cordial in return. After talking, R47 said she told R37 that she would be going back to her room, and R47 alleged that was when R37 reached out and "grabbed my boob." R47 said he "grabbed it hard, and it hurt." R47 described telling staff about it right away, and said the police even came out to talk to her. R47 said nothing like that had ever happened before, and it never happened again since the incident on 12/29/18. R47 said she felt safe in the facility when she could keep her distance from R37. R47 felt that sometimes it seemed R37 loitered outside her room, and that made her uncomfortable. R47 alleged she had told him that he could not come in her room, as no men were allowed in her room. R47 said some staff seemed to keep a closer eye on the situation than others, but again confirmed that if she did not have to be too close to R37,	F 610	Recurrence will be prevented by: Audits of all res-res altercations will occur x 60 days to assure Reported to MDH, separating residents, interviewing residents, other potential witnesses, other residents and staff, new interventions in place, Care Plan is updated, staff alerted to any changes, and Administrator, MD and Resident Representative notified. The correction will be monitored by: Administrator/Social Services Director	

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F 610	Continued From page 3	F 610		

she felt okay.

During interview on 1/23/19, at 1:58 p.m. trained medication aide (TMA)-D was asked about awareness to any incidents between R47 and R37. TMA-D was not aware of anything going on between the two residents, and had not observed them to interact. At 2:03 p.m. health unit coordinator (HUC)-P said R47 floated around and talked to residents, but was not aware of any concerns. At 2:27 p.m. certified nursing assistant (CNA)-Q was asked, but was also not aware of any inappropriate incidents between R37 and R47.

During interview on 1/24/19, at 10:11 a.m. when asked about any incidents between R47 and R37, TMA-C was not aware of any incidents between R37 and R47. TMA-C noted that R47 was a social person, but never noticed anything inappropriate between the residents. At 10:17 a.m. registered nurse (RN)-J was not aware of any incidents between R37 and R47.

During interview on 1/24/19, at 10:56 a.m. RN-B said R37 was kind of aphasic (disorder resulting from damage or injury to the language part of the brain that can lead to impairment of speaking, and comprehension), and might not always understand what was right or wrong. RN-B was not working at the time of the alleged incident, and said the nurse on duty was responsible for getting statements from staff at the time of the incident. RN-B said this incident had been reported to staff by R47, and had not been witnessed by anyone else. RN-B said that residents also needed to be interviewed after allegations of abuse. When asked if interviews with staff or residents were documented, RN-B

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F 610	Continued From page 4	F 610		

offered to look for the documentation and follow-up. RN-B said that R47 regularly spoke with her, and that nothing else had come up regarding the alleged incident, nor had communicated still being uncomfortable around R37. RN-B confirmed R47 was educated about staying away from R37 because of his cognition limitations, and not initiating hugs, however RN-B had not observed R47 to hug other residents. RN-B said there were no other interventions other than directing R47 to stay away from R37 and for R37 to not offer or request hugs from other residents. RN-B added that R37 was withdrawn, and did not socialize. RN-B was unaware that R47 felt uncomfortable seeing R37 now, and said a room change could be offered to R47 as an option to move farther away from R37.

During a follow-up interview on 1/24/19, at 2:35 p.m. RN-B confirmed there was no documentation of interviews with staff and residents. RN-B wanted to talk to the nurse who was working at the time of the incident, and try to piece the investigation together again.

The facility's Prohibit Plan, dated 8/15, was a process designed to provide a consistent method to reduce patient risk, reduce opportunity for repeat occurrences, and identify root cause of events, such as incidents, complaints, and resident to resident altercations. The plan included the requirement to gather information from all parties witness to the concern, and determine the who, what, where, when, how, and why. The plan required staff to write down interviews, and take written statements. The plan also asked for a discussion around how the resident was affected, and whether other residents were at risk.

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F 610	Continued From page 5 Review of the Abuse Prevention Plan - MN, last revised 11/18, revealed that after changes were made to keep a resident safe, there should be follow-up review of the changes implemented to make sure they were appropriate for a resident and the condition of the resident.	F 610		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure 4 of 4 residents (R506, R78, R83 and R504) reviewed for medication administration and physician medication orders, were free of significant medication errors. Findings include: R506's Face sheet indicated admission of 11/24/18, with diagnoses which included pyothorax (presence of inflammatory fluid or "pus" within the chest cavity, which is the area between the lungs and the inner walls of the ribs), without fistula and sepsis. An Admissions Confidence sheet indicated R506 had IV antibiotics medication. R506's Hospital transfer orders dated 11/24/18, at 9:17 a.m. indicated the following antibiotics were to be administered: "CEPHALOSPORIN IV THERAPY PLAN protocol Cephalosporin IV therapy plan - as of 11/24/2018, at 9:02 AM, maintenance therapy	F 760	F760 E Residents are free of Significant Medication Errors Immediate corrective action: Resident #83 discharged from the facility on 2/15/2019. Resident #506 discharged from the facility on 11/25/2018. Resident # 504 discharged from the facility on 1/20/2019. Resident #78 remains in the facility and the nurse who changed the medication order without notifying the physician was terminated. Action as it applies to others: The Policy and Procedures on Physician Orders, Medication Orders and Medication not Readily available were reviewed and remain current. Immediate education for all licensed nurses and TMA□s was started on Physician Order Procedure Policy, Medication Orders Policy and the Policy on Medication not readily available. A second training held to show emphasis on procedures to assure a second check of	2/20/19

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F 760	Continued From page 6 ceftriaxone (ROCEPHIN) 2 g in sodium chloride 0.9% 100 mL IVPB 2 g, Intravenous, Administer over 30 Minutes Q24H (NON-STND) Starting when released for 1 dose, Administer q24h". Hospital Fax transmission form dated 11/24/18 at 11:00 a.m., indicated: "CEPHALOSPORIN IV THERAPY PLAN Treatment Start Date 11/24/2018, Protocol CEPHALOSPORIN IV THERAPY PLAN - As of 11/24/2018 9:02 AM." Care Plan provided, print date 1/24/19, did not indicate R506 received an antibiotic. The 11/18, medication administration record (MAR) indicated R506 did not receive Ceftriaxone Sodium and NaCl, 2g IV on 11/25/18, due to hospitalization. Progress note dated 11/25/18, at 10:40 a.m. indicated R506 stated he was going to hospital around 10:30 a.m., may not come back to facility, signed an against medical advice form before leaving, and all morning medications were administered on time. Review of progress notes indicated there was no progress note to the physician regarding notification R506 did not receive IV antibiotic medication on 11/24/18 or 11/25/18. During an interview on 1/24/19, at 10:44 a.m. the pharmacy consultant (PC) was unable to provide information on discharged residents. Pharmacist did indicate the rec(-Gord showed seven doses of Rocephin were filled, 4 doses on 11/24/18, and 3 doses on 11/27/18. During an interview on 1/24/19, at 11:49 a.m.,	F 760	all medication orders completed and MD notified for orders if a medication is not available. Date of completion: 2/20/2019 Recurrence will be prevented by: 2 Audits will occur x 60 days with results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue audits. First audit is 5 residents weekly on various units to assure MD notified for orders if a medication is not readily available. Second audit is all new admissions/readmissions on any unit reviewed within 24 hours to assure all medication orders were transcribed correctly. The correction will be monitored by: DON/Nurse Managers	

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F 760	Continued From page 7	F 760		

registered nurse (RN)-G indicated she could not remember when the IV medication was ordered. When a resident came from the hospital preliminary orders were sent to the pharmacy before arrival and admission staff took care of ordering needed medications. When a resident physically arrived the final orders brought with the resident were reviewed. The nurse and health unit coordinator would then fax orders to the pharmacy. For new admissions, medication/s should arrive within four hours after being faxed to the pharmacy. RN-G stated the pharmacy operated 24 hours and would deliver at night. RN-G further indicated the E-kit only stored tablets, not IV medications.

On 1/24/19 at 12:48 p.m., RN-G stated she did not believe the facility received the antibiotic medication on 11/24/18. RN-G further explained they always removed IV medication from the refrigerator to warm it up first before administering and the resident did not want to wait for medication to warm up and left for the hospital the moring of 11/25/18.

R78's medical record revealed, R78 was readmitted to the facility on 12/8/18, with physician orders that read, "Bumetanide tablet 2 mg [milligram] Give 1 mg by mouth one a day for Edema". However, on 12/12/18, licensed practical nurse (LPN)-Z happened to look through R78 medical record and thought physician order should be Bumetanide tablet 1 mg twice daily. LPN-Z changed the physician order without contacting the nurse practitioner (NP) or the medical doctor (MD). On 1/4/19, LPN-Y discovered the medication error and updated NP. NP held the medication.

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F 760	Continued From page 8	F 760		

Progress note dated 1/4/19 at 7:38 a.m., revealed, "NP ... was paged about Bumetanide order which was wrongly transcribes and has been administered since 12/11/18. She told this writer to hold it till she comes in on 1/4/19 and review the order."

The administration record for December 2018 and January 2019 revealed, R78 received Bumetanide 2 mg tablet; give 1 mg by mouth two times a day for edema, diastolic heart failure from 12/13/18 through 1/3/19.

On 1/23/19, at 12:44 p.m., RN-Z verified LPN-Z had changed the medical provider's order without seeking advice from the MD/NP. RN-Z indicated there was a one-time incident where an LPN changed MD/NP orders without consulting with the MD/NP and she did not return to work following the investigation.

R83's medication error report dated 1/19/19, at 9:32 a.m. indicated " ... Resident missed her scheduled insulin in the morning on 1/19/19 for running out of supply. Resident did receive her evening insulin when supply arrived. There was no adverse reaction noted. Administrator notified, investigation pending ..."

A review of medications on R83's Physician's Order Report dated 10/29/18, revealed Insulin Detemir 30 units subcutaneously two times a day. The physician's order indicated the Insulin Detemir was to start on 10/29/18, and continue twice a day.

Progress note dated 1/19/19 at 2:56 p.m. revealed "Insulin Detemir not available, called the

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F 760	Continued From page 9	F 760		

pharmacy 3x with stat order and floor manager called the pharmacy too. as [SIK] of 3 pm medication did not arrived yet. pm [evening] nurse was informed." However, neither the NP or MD were notified of the missed insulin dose.

On 1/24/19 at 10:50 a.m., pharmacy technician stated facility staff requested the Insulin Detemir on 1/19/19 stat [immediate order] at 10:30 a.m. and the insulin was sent at 2:30 p.m. and the normal delivery time is four hours, Pharmacy Technician was unsure why the insulin as delivered in four hours if it was ordered as stat.

On 1/24/19 at 11:49 a.m. R83 stated the 8:00 a.m. dose of insulin Detemir was not administered on time 1/19/19, because the facility had run out of it.

On 1/24/19 at 12:11 p.m., RN-X verified R83 did not received the 8:00 a.m., dosage of Insulin Detemir. RRN-X mentioned, LPN-X updated RN-X around 10:00 a.m. regarding running out of Insulin Detemir for R83. RN-X said, LPN-X told RN-X that RN-S was updated and RN-S placed a called to Omnicare pharmacy, but did not order the medication stat. RN-X indicated that LPN-X was reeducated regarding critical medications needing to be ordered from the pharmacy stat when the medication had run out. RN-X added, the insulin arrived to the facility at 4:00 p.m., the evening shift nurse LPN-S administered the night dosage instead at 7:06 p.m. MD/NP was not updated due to no signs/symptoms of high blood sugar and blood sugar was 280 at 4:40 p.m.

R504's record review revealed, R504 was admitted to the facility on 1/14/19 and was discharge on 1/20/19. Review of incident of

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transcription errors revealed an error occurred on 1/14/19 and it read, "Resident was admitted from Region hospital on 1/14/19. Orders were sent to facility prior to resident arriving and entered into EMR [electronic medical record]. Resident arrived later in day with a packet of information including additional orders for antibiotics which were not entered into EMR. Error discovered 1/17/19. Error discovered 1/17/19. Investigation has begun into root cause ..."

A review of medications on R504's Physician's Transfer Order Report dated 1/14/18, revealed cephalexin 500 mg one capsule for cellulitis and was to be administered by mouth every eight hours for 8 days.

R504's January 2019 electronic medication administration record (eMAR), revealed, R504 did not receive cephalexin 500 mg one capsule by mouth every eight hours for 8 days to treat cellulits from 1/14 through the morning of 1/17/19.

On 1/24/19, at 10:44 a.m., the PC stated, facility staff ordered cephalexin on 1/17/19 but could not recall or access time. In addition, PC indicated that facility staff could have used the E-kit because the E-kit had cephalexin.

On 1/24/19, at 11:57 a.m., RN-X verified R504's admission transfer order included cephalexin medication. RN-X stated LPN-R indicated he had compared the preliminary orders and admit orders. However, LPN-R made a transcription error and LPN-R received coaching and re-education. Furthermore, RN-X mentioned, her expectation was when the resident came from the hospital, nursing staff should compare the

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preliminary orders and admission transfer order that resident came with.

Medication Administration and Ordering Policy dated Nov 20, 2017 indicated: "8. Any error related to administration of a medication or adverse drug reaction of a medication must be reported immediately to the nurse in charge and Nursing Service Office. Complete "Report of Medication Error and Incident Report" before the end of your scheduled tour of duty."

Policy and procedure title PHYSICIAN ORDER PROCEDURE dated July 2017, read, "To correctly and safely receive transcribe physician's orders so correct order is followed/administered ... The order should be written into the resident's medical record exactly as it was stated by the physician. All orders must contain name, strength, route, dose, and quantity or specific duration of therapy. Order must also contain specific and clear parameters ..."

Policy and procedure title PHYSICIAN MEDICATION ORDERS dated June 2013, revealed, " ...1. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses ..."

Policy and procedure title MEDICATION NOT READILY AVAILABLE dated June 2014, directed staff; " ... 2. Depending upon the time the medication is anticipated for delivery and the purpose of the medication, the following measures can be taken ... Obtain medication from back-up pharmacy ..."

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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/s H5295154C, H5295149, H5295151, H5295153C, H5295155C, H5295156C, H5295157C, H5295158C, H5295159C, H5295160C and H5295161C. As a result the following correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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	21545		2/20/19

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21545	Continued From page 2 requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure 4 of 4 residents (R506, R78, R83 and R504) reviewed for medication administration and physician medication orders, were free of significant medication errors. Findings include: R506's Face sheet indicated admission of 11/24/18, with diagnoses which included pyothorax (presence of inflammatory fluid or "pus" within the chest cavity, which is the area	21545	corrected.	

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21545	Continued From page 3 between the lungs and the inner walls of the ribs), without fistula and sepsis. An Admissions Confidence sheet indicated R506 had IV antibiotics medication. R506's Hospital transfer orders dated 11/24/18, at 9:17 a.m. indicated the following antibiotics were to be administered: "CEPHALOSPORIN IV THERAPY PLAN protocol Cephalosporin IV therapy plan - as of 11/24/2018, at 9:02 AM, maintenance therapy ceftriaxone (ROCEPHIN) 2 g in sodium chloride 0.9% 100 mL IVPB 2 g, Intravenous, Administer over 30 Minutes Q24H (NON-STND) Starting when released for 1 dose, Administer q24h". Hospital Fax transmission form dated 11/24/18 at 11:00 a.m., indicated: "CEPHALOSPORIN IV THERAPY PLAN Treatment Start Date 11/24/2018, Protocol CEPHALOSPORIN IV THERAPY PLAN - As of 11/24/2018 9:02 AM." Care Plan provided, print date 1/24/19, did not indicate R506 received an antibiotic. The 11/18, medication administration record (MAR) indicated R506 did not receive Ceftriaxone Sodium and NaCl, 2g IV on 11/25/18, due to hospitalization. Progress note dated 11/25/18, at 10:40 a.m. indicated R506 stated he was going to hospital around 10:30 a.m., may not come back to facility, signed an AMA form before leaving and all morning medications were administered on time. Review of progress notes indicated there was no progress note to the physician regarding notification R506 did not receive IV antibiotic medication on 11/24/18 or 11/25/18.	21545		

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21545	Continued From page 4 During an interview on 1/24/19, at 10:44 a.m. the pharmacy consultant (PC) was unable to provide information on discharged residents. Pharmacist did indicate the record showed seven doses of Rocephin were filled, 4 doses on 11/24/18, and 3 doses on 11/27/18. During an interview on 1/24/19, at 11:49 a.m., registered nurse (RN)-G indicated she could not remember when the IV medication was ordered. When a resident came from the hospital preliminary orders were sent to the pharmacy before arrival and admission staff took care of ordering needed medications. When a resident physically arrived the final orders brought with the resident were reviewed. The nurse and health unit coordinator would then fax orders to the pharmacy. For new admissions, medication/s should arrive within four hours after being faxed to the pharmacy. RN-G stated the pharmacy operated 24 hours and would deliver at night. RN-G further indicated the E-kit only stored tablets, not IV medications. On 1/24/19 at 12:48 p.m., RN-G verified the facility did receive the antibiotic medication (when did they receive it???.) RN-G explained they always removed IV medication from the refrigerator to warm it up first before administering. The resident did not want to wait for medication to warm up and left for the hospital. (is this note regarding 11/25/18 med admin?) R78's medical record revealed, R78 was readmitted to the facility on 12/8/18, with physician orders that read, "Bumetanide tablet 2 mg [milligram] Give 1 mg by mouth one a day for Edema". However, on 12/12/18, licensed practical	21545		

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nurse (LPN)-Z happened to look through R78 medical record and thought physician order should be Bumetanide tablet 1 mg twice daily. LPN-Z changed the physician order without contacting the nurse practitioner (NP) or the medical doctor (MD). On 1/4/19, LPN-Y discovered the medication error and updated NP. NP held the medication.

Progress note dated 1/4/19 at 7:38 a.m., revealed, "NP ... was paged about Bumetanide order which was wrongly transcribes and has been administered since 12/11/18. She told this writer to hold it till she comes in on 1/4/19 and review the order."

The administration record for December 2018 and January 2019 revealed, R78 received Bumetanide 2 mg tablet; give 1 mg by mouth two times a day for edema, diastolic heart failure from 12/13/18 through 1/3/19.

On 1/23/19, at 12:44 p.m., RN-Z verified LPN-Z had changed the medical provider's order without seeking advice from the MD/NP. RN-Z indicated there was a one-time incident where an LPN changed MD/NP orders without consulting with the MD/NP and she did not return to work following the investigation.

R83's medication error report dated 1/19/19, at 9:32 a.m. indicated " ... Resident missed her scheduled insulin in the morning on 1/19/19 for running out of supply. Resident did receive her evening insulin when supply arrived. There was no adverse reaction noted. Administrator notified, investigation pending ..."

A review of medications on R83's Physician's Order Report dated 10/29/18, revealed Insulin

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21545	Continued From page 6 Detemir 30 units subcutaneously two times a day. The physician's order indicated the Insulin Detemir was to start on 10/29/18, and continue twice a day. Progress note dated 1/19/19 at 2:56 p.m. revealed "Insulin Detemir not available, called the pharmacy 3x with stat order and floor manager called the pharmacy too. as [SIK] of 3 pm medication did not arrived yet. pm [evening] nurse was informed." However, neither the NP or MD were notified of the missed insulin dose. On 1/24/19 at 10:50 a.m., pharmacy technician stated facility staff requested the Insulin Detemir on 1/19/19 stat [immediate order] at 10:30 a.m. and the insulin was sent at 2:30 p.m. and the normal delivery time is four hours, Pharmacy Technician was unsure why the insulin as delivered in four hours if it was ordered as stat. On 1/24/19 at 11:49 a.m. R83 stated the 8:00 a.m. dose of insulin Detemir was not administered on time 1/19/19, because the facility had run out of it. On 1/24/19 at 12:11 p.m., RN-X verified R83 did not received the 8:00 a.m., dosage of Insulin Detemir. RRN-X mentioned, LPN-X updated RN-X around 10:00 a.m. regarding running out of Insulin Detemir for R83. RN-X said, LPN-X told RN-X that RN-S was updated and RN-S placed a called to Omnicare pharmacy, but did not order the medication stat. RN-X indicated that LPN-X was reeducated regarding critical medications needing to be ordered from the pharmacy stat when the medication had run out. RN-X added, the insulin arrived to the facility at 4:00 p.m., the evening shift nurse LPN-S administered the night dosage instead at 7:06 p.m. MD/NP was not	21545		

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updated due to no signs/symptoms of high blood sugar and blood sugar was 280 at 4:40 p.m.

R504's record review revealed, R504 was admitted to the facility on 1/14/19 and was discharge on 1/20/19. Review of incident of transcription errors revealed an error occurred on 1/14/19 and it read, "Resident was admitted from Region hospital on 1/14/19. Orders were sent to facility prior to resident arriving and entered into EMR [electronic medical record]. Resident arrived later in day with a packet of information including additional orders for antibiotics which were not entered into EMR. Error discovered 1/17/19. Error discovered 1/17/19. Investigation has begun into root cause ..."

A review of medications on R504's Physician's Transfer Order Report dated 1/14/18, revealed cephalexin 500 mg one capsule for cellulitis and was to be administered by mouth every eight hours for 8 days.

R504's January 2019 electronic medication administration record (eMAR), revealed, R504 did not receive cephalexin 500 mg one capsule by mouth every eight hours for 8 days to treat cellulits from 1/14 through the morning of 1/17/19.

On 1/24/19, at 10:44 a.m., the PC stated, facility staff ordered cephalexin on 1/17/19 but could not recall or access time. In addition, PC indicated that facility staff could have used the E-kit because the E-kit had cephalexin.

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orders. However, LPN-R made a transcription error and LPN-R received coaching and re-education. Furthermore, RN-X mentioned, her expectation was when the resident came from the hospital, nursing staff should compare the preliminary orders and admission transfer order that resident came with.

Medication Administration and Ordering Policy dated Nov 20, 2017 indicated: "8. Any error related to administration of a medication or adverse drug reaction of a medication must be reported immediately to the nurse in charge and Nursing Service Office. Complete "Report of Medication Error and Incident Report" before the end of your scheduled tour of duty."

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21545	Continued From page 9 measures can be taken ... Obtain medication from back-up pharmacy ..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		