



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112
Ramsey County

Report#: H5310055

Date: May 12, 2016

Date of Visit: March 30, 2016

By: Deborah Neuberger, RN, Special Investigator

Time of Visit: 8:30 a.m. - 3:15 p.m.

Type of Facility: Nursing Home HHA Home Care Provider
 SLF ICF/IID
 Hospital Other: _____

Facility Self Report Complaint

Allegation(s): **It is alleged** that a resident was neglected when s/he was administered the incorrect medication and s/he developed a brain bleed.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

Abuse Neglect Financial Exploitation was:

Substantiated Not Substantiated Inconclusive based on the following information:

Based on a preponderance of evidence neglect did occur when facility staff administered Coumadin (a blood thinner) to the resident in error over a period of 14 days. The resident was hospitalized and required treatment including a craniotomy.

The resident's admission to the facility occurred in early March 2016 with multiple fractures after an accident. The resident's physician orders included Lovenox injection daily (blood thinner) 40 mg/o. 4 ml solution daily for 28 days. There was no physician's order for Coumadin. However, the resident's Electronic Medication Administration Record (EMAR) was reviewed and revealed that the resident received Coumadin 4 mg for six days and 7 mg for eight days. During a care conference the resident's family questioned why the resident was taking Coumadin. A staff member reviewed the resident's chart and found no order for Coumadin.

Administration was notified and the following day the resident's blood was checked. An INR (a laboratory test that measure of how quickly blood clots) was drawn and was 10.73 "High Critical" with the normal reference range being 0.90 - 1.10. The resident's was transferred to the hospital due to elevated INR, and the resident was lethargic and less responsive.

The resident's hospital record revealed the resident was admitted to the hospital on 3/23/2016 with diagnoses that included Subdural Hematoma (an accumulation of blood on the brain's surface beneath the skull.) The resident underwent a craniotomy for hematoma evacuation.

During an interview, the resident's physician stated s/he first learned of the medication error after the laboratory results were completed. Initially the resident was asymptomatic and medical staff ordered 5 mg Vitamin K for the resident. A couple days after the error was identified the resident experienced mental status changes and was transferred to the hospital. Neither the physician nor nurse practitioner working with the physician ordered Coumadin for staff to administer to the resident.

The resident's family members were interviewed and stated they questioned the order for Coumadin, but facility staff told them the resident had a valid order for Coumadin. On the day the resident was transferred to the hospital, they visited the resident and were not able to waken the resident. They alerted facility staff and requested the resident be transferred to the hospital. When the resident went to the hospital his/her diagnosis included a brain bleed and s/he had surgery to remove the blood (Craniotomy.) The resident is currently recovering at another care facility.

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 had policies and procedures in place for entering and verifying physician orders to ensure accuracy. Two staff failed to follow policies and entered the order in the wrong resident electronic medical record, and numerous facility staff members gave the incorrect medication to the resident for 14 days.

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 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 If no, specify: _____

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

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.

State Statutes Chapters 144 & 144A – Compliance Not Met

The requirements under State Statutes for Chapters 144 & 144A were not met.

State licensing orders were issued: Yes No If no, specify: _____

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

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

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

The Investigation included the following:

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

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input checked="" type="checkbox"/> Medication Administration Records | <input checked="" type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input checked="" type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Social Service Notes |
| <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Meal Intake Records |
| <input type="checkbox"/> Activities Reports | <input type="checkbox"/> Weight Records |
| <input type="checkbox"/> Therapy and/or Ancillary Services Records | <input checked="" type="checkbox"/> Assessments |

Skin Assessments

Care Plan Records

Service Plan

Other, specify: Medication error reports

Other pertinent medical records:

Hospital Records

Ambulance/Paramedics

Medical Examiner Records

Death Certificate

Police Report

Other, specify: _____

Additional facility records:

Resident/Family Council Minutes

Personnel Records/Background Check, etc.

Staff Time Sheets, Schedules, etc.

Facility In-service Records

Facility Internal Investigation Reports

Facility Policies and Procedures

Call Light Audits

Other, specify: _____

Number of additional resident(s) reviewed: 4

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: _____

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: Unavailable.

Did you interview additional residents: Yes No

Total number of resident interviews: 4

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

Tennessee Warning given as required: Yes No

Total number of staff interviews: 12

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:

- Wound Care
- Medication Pass
- Meals
- Personal Care
- Dignity/Privacy Issues
- Restorative Care
- Nursing Services
- Safety Issues
- Facility Tour
- Infection Control
- Cleanliness
- Injury
- Use of Equipment
- Transfers
- Incontinence
- Call Light
- Other: _____

Was any involved equipment inspected: Yes No N/A Specify: _____

Was equipment being operated in safe manner: Yes No N/A Specify: _____

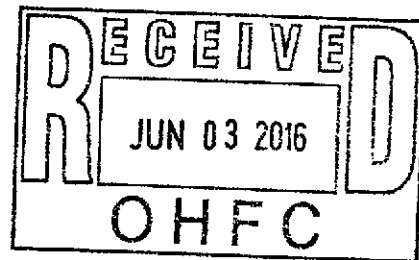
Were photographs taken: Yes No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Nursing
Minnesota Board of Pharmacy
New Brighton City Police Department
Ramsey County Attorney
New Brighton City Attorney

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

PRINTED: 05/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medications free of significant medication errors for 1 of 6 residents reviewed, Resident #1 (R1), when the resident was administered Coumadin (blood thinner) for 14 days, when he had no physician's order for Coumadin. R1 was hospitalized, and he developed a subdural hematoma which required craniotomy treatment. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility on 3/2/2016 with diagnoses that included multiple fractures after having been struck by a car, and hypertension. R1's careplan dated 3/8/2016 revealed R1 required the assistance of one staff member with self care including bathing, dressing and grooming.</p> <p>R1's physician orders dated 3/2/2016 included Lovenox injection daily (blood thinner) 40 mg/o. 4 ml solution daily for 28 days. No physician order for Coumadin was found in R1's medical record.</p> <p>R1's Electronic Medication Administration Record (EMAR) was reviewed and revealed that R1</p>	F 333	<p>1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The patient was immediately sent to the hospital due to the decreased level of consciousness. He had surgery and has recovered. He has been discharged home.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same</p>		



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

[Signature]

TITLE

Administrative

(X6) DATE

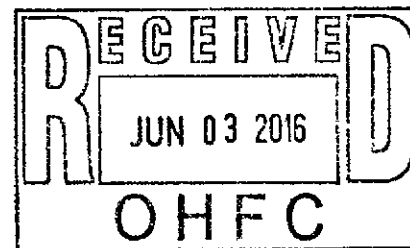
6/2/16

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2016
FORM APPROVED
OMB NO. 0938-0391

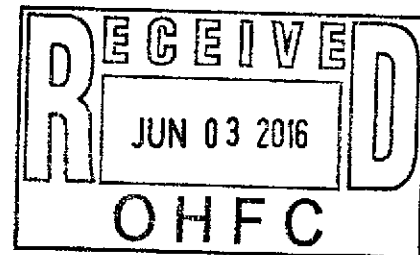
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 1</p> <p>received Coumadin on 3/8/2016 - 3/21/2016, for a total of 14 doses over 14 days. 4 mg. on 3/8, 3/9, 3/10, 3/15, 3/16, and 3/17/2016. 7 mg. on 3/11, 3/12, 3/13, 3/14, 3/18, 3/19, 3/20, and 3/21/2016.</p> <p>R1's laboratory results dated 3/22/2016 collected at 7:30 a.m. revealed R1's INR (a measure of blood clotting) was measured at 10.73 "High Critical" with the normal reference range being 0.90 - 1.10.</p> <p>R1's Resident Transfer Form, dated 3/23/2016 revealed R1 was sent to the hospital due to elevated INR, and the resident was lethargic and less responsive.</p> <p>The resident 's hospital record revealed the resident was admitted to the hospital on 3/23/2016 with diagnoses that included Subdural Hematoma (an accumulation of blood on the brain's surface beneath the skull.) The resident underwent a craniotomy for hematoma evacuation.</p> <p>An interview with Registered Nurse N (RN-N) was conducted on 3/31/2016 at 11:10 a.m. RN-N stated on 3/21/2016 care conference for R1 was conducted and during that conference R1's family questioned why he was taking Coumadin. RN-N stated she reviewed R1's chart and could find no order for Coumadin. RN-N then reported the concern to RN, Assistant Director of Nursing B (ADON-B) on 3/21/2016. RN-N stated ADON-B later told her that there was a valid order for the Coumadin from R1's Nurse Practitioner. RN-N stated on 3/22/2016 R1's Nurse Practitioner came in and RN-N asked her if there was an</p>	F 333	<p>deficient practice.</p> <p>Reviewed report of all patients with orders for Coumadin and reviewed their medical record. Placed nursing order to identify all patients who take Coumadin which explains what to do. No discrepancies found in orders and records.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Initiated policy of 2 licensed staff checking all physician orders after order is written.</p>		



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

PRINTED: 05/24/2016
FORM APPROVED
OMB NO. 0938-0391

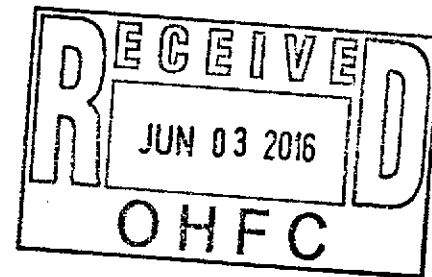
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 2</p> <p>order for R1 to have Coumadin. No order for Coumadin was found. RN-N stated she was very concerned about the issue, because the Coumadin dose was quite high for someone who had not used Coumadin before.</p> <p>An interview with ADON-B was conducted on 3/30/2016 at 10:10 a.m. ADON-B stated RN-N asked him about R1's Coumadin order on 3/21/2016. ADON-B stated he looked in R1's EMAR and saw a valid order for Coumadin in the resident's orders. When asked if he looked at the written physicians orders to validate the order, he stated he did not, but looked in the computer, because each computer order is validated by a licensed nurse with the written physician's order. On 3/22/2016 R1's INR was drawn and was very high. ADON-B then compared R1's written physician's orders with what was in his EMAR and R1 had received numerous doses of Coumadin, for which he had no physician's order. Health Unit Coordinator I (HUC-I) entered the order and Licensed Practical Nurse H (LPN-H) verified the order. Nursing staff called R1's Nurse Practitioner who ordered oral Vitamin K. Later R1 became less responsive and was sent to the Emergency Department (ED) for treatment.</p> <p>An interview with HUC-I was conducted on 3/31/2016 at 2:00 p.m. HUC-I stated she recalled R1, but did not recall entering an order for Coumadin into the electronic medical record for him. HUC-I stated she reviewed the record and the record indicates she entered the order, and no other staff member could have used her name to enter the order. HUC-I stated the only explanation she has is that she must have entered another resident's Coumadin order into R1's EMAR.</p>	F 333	<p>All licensed nurses were trained in new policies.</p> <p>4. How the facility plans to monitor its performance to make sure that solutions are sustained. Review medications on admission and quarterly in care conferences. Issues discussed with family at these times also.</p> <p>5. Include dates when corrective action will be completed. March 30, 2016</p>		



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

PRINTED: 05/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	Continued From page 3 An interview with LPN-H was conducted on 4/1/2016 at 1:10 p.m. LPN-H stated she did not recall verifying the Coumadin order for R1, but her name was in the computer, so she must have done so. LPN-H had no explanation for the error except perhaps she made an error. No other staff member could have verified it, because they use passwords for all their computer work. An interview with R1's physician (MD-K) was conducted on 3/31/2016 at 10:22 a.m. and revealed she first learned of the medication error on 3/22/2016, when her Nurse Practitioner called to tell her that R1's INR was over 10. Initially R1 was asymptomatic and was given 5 mg Vitamin K orally. On 3/23/2016 he experienced mental status changes and he was sent to the ED. MD-K stated no one from her office, including herself or any nurse practitioner, ordered Coumadin for R1. An interview was conducted with R1's family including 2 of his daughters and R1's wife on 4/7/2016 at 1:00 p.m. R1's family stated they initially questioned why R1 was getting Coumadin on 3/8/2016. LPN-H told them that R1's physician ordered the medication. When R1 saw his orthopedic doctor on 3/16/2016 the family asked him about the Coumadin. He stated he did not order the Coumadin. On 3/21/2016 the facility held a care conference for R1 and the family again questioned the Coumadin, asking RN-N about the medication. RN-N stated she would investigate why R1 was taking the medication. On 3/22/2016 the family observed R1 was more tired than usual. On 3/23/2016 the family visited and they were unable to wake the resident. The family alerted facility staff and asked them to call 911. R1 was transported to the hospital, and was	F 333			



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

PRINTED: 05/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 4</p> <p>diagnosed with a brain bleed. The resident had surgery (craniotomy) the next day to remove the blood. R1 is now recovering at another facility and he seems to be slowly getting better.</p> <p>The policy titled Prescriber Medication Orders, undated and provided by the facility revealed: Medications are administered only according to the clear, complete and signed order of a person lawfully authorized to prescribe. 1. Each medication order is documented in the resident's medical record with the date, times and signature of the person receiving the order. The order is recorded on the physician order sheet and the Medication Administration Record. (MAR).</p> <p>The policy Titled Putting in Medication Orders, undated and provided by the facility revealed under 7. e. ii. 1. If a HUC put the original order in a licensed nurse must verify the order prior to administration. a. EMAR will not allow administration of an order without it being verified.</p>	F 333			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5310055. As a result, the following correction orders are issued.</p>	2 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p>	

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1	2 000	<p>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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
21545	<p>MN Rule 4658.1320 A.B.C Medication Errors</p> <p>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</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 2</p> <p>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:</p> <p>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or</p> <p>(2) the administration of expired medications.</p> <p>B. It is free of any significant medication error. A significant medication error is:</p> <p>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or</p> <p>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error 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.</p> <p>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.</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLACK OAK DRIVE
NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide medications free of significant medication errors for 1 of 6 residents reviewed, Resident #1 (R1), when the resident was administered Coumadin (blood thinner) for 14 days, when he had no physician's order for Coumadin. R1 was hospitalized, and he developed a subdural bleed which required craniotomy treatment. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility on 3/2/2016 with diagnoses that included multiple fractures after having been struck by a car, and hypertension. R1's careplan dated 3/8/2016 revealed R1 required the assistance of one staff member with self care including bathing, dressing and grooming.</p> <p>R1's physician orders dated 3/2/2016 included Lovenox injection daily (blood thinner) 40 mg/o. 4 ml solution daily for 28 days. No physician order for Coumadin was found in R1's medical record.</p> <p>R1's Electronic Medication Administration Record (EMAR) was reviewed and revealed that R1 received Coumadin on 3/8/2016 - 3/21/2016, for a total of 14 doses over 14 days. 4 mg. on 3/8, 3/9, 3/10, 3/15, 3/16, and 3/17/2016. 7 mg. on 3/11, 3/12, 3/13, 3/14, 3/18, 3/19, 3/20, and 3/21/2016.</p> <p>R1's laboratory results dated 3/22/2016 collected at 7:30 a.m. revealed R1's INR was measured at 10.73 "High Critical" with the normal reference range being 0.90 - 1.10.</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 4</p> <p>R1's Resident Transfer Form, dated 3/23/2016 revealed R1 was sent to the hospital due to elevated INR, and the resident was lethargic and less responsive.</p> <p>The resident 's hospital record revealed the resident was admitted to the hospital on 3/23/2016 with diagnoses that included Subdural Hematoma (an accumulation of blood on the brain's surface beneath the skull.) The resident underwent a craniotomy for hematoma evacuation.</p> <p>An interview with Registered Nurse N (RN-N) was conducted on 3/31/2016 at 11:10 a.m. RN-N stated on 3/21/2016 care conference for R1 was conducted and during that conference R1's family questioned why he was taking Coumadin. RN-N stated she reviewed R1's chart and could find no order for Coumadin. RN-N then reported the concern to RN, Assistant Director of Nursing-B on 3/21/2016. RN-N stated ADON-B later told her that there was a valid order for the Coumadin from R1's Nurse Practitioner. RN-N stated on 3/22/2016 R1's Nurse Practitioner came in and RN-N asked her if there was an order for R1 to have Coumadin. No order for Coumadin was found. RN-N stated she was very concerned about the issue, because the Coumadin dose was quite high for someone who had not used Coumadin before.</p> <p>An interview with ADON-B was conducted on 3/30/2016 at 10:10 a.m. ADON-B stated RN-N asked him about R1's Coumadin order on 3/21/2016. ADON-B stated he looked in R1's EMAR and saw a valid order for Coumadin in the resident's orders. When asked if he looked at the written physicians orders to validate the order, he stated he did not, but looked in the computer,</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 5</p> <p>because each computer order is validated by a licensed nurse with the written physician's order. On 3/22/2016 R1's INR was drawn (a measure of blood clotting) and was very high. ADON-B then compared R1's written physician's orders with what was in his EMAR and R1 had received numerous doses of Coumadin, for which he had no physician's order. Health Unit Coordinator I (HUC-I) entered the order and Licensed Practical Nurse H (LPN-H) verified the order. Nursing staff called R1's Nurse Practitioner who ordered oral Vitamin K. Later R1 became less responsive and was sent to the Emergency Department (ED) for treatment.</p> <p>An interview with HUC-I was conducted on 3/31/2016 at 2:00 p.m. HUC-I stated she recalled R1, but did not recall entering an order for Coumadin into the electronic medical record for him. HUC-i stated she reviewed the record and the record indicates she entered the order, and no other staff member could have used her name to enter the order. HUC-I stated the only explanation she has is that she must have entered another resident's Coumadin order into R1's EMAR.</p> <p>An interview with LPN-H was conducted on 4/1/2016 at 1:10 p.m. LPN-H stated she did not recall verifying the Coumadin order for R1, but her name was in the computer, so she must have done so. LPN-H had no explanation for the error except perhaps she made an error. No other staff member could have verified it, because they use passwords for all their computer work.</p> <p>An interview with R1's physician (MD-K) was conducted on 3/31/2016 at 10:22 a.m. and revealed she first learned of the medication error on 3/22/2016, when her Nurse Practitioner called</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 6</p> <p>to tell her that R1's INR was over 10. Initially R1 was asymptomatic and was given 5 mg Vitamin K orally. On 3/23/2016 he experienced mental status changes and he was sent to the ED. MD-K stated no one from her office, including herself or any nurse practitioner, ordered Coumadin for R1.</p> <p>An interview was conducted with R1's family including 2 of his daughters and R1's wife on 4/7/2016 at 1:00 p.m. R1's family stated they initially questioned why R1 was getting Coumadin on 3/8/2016. LPN-H told them that R1's physician ordered the medication. When R1 saw his orthopedic doctor on 3/16/2016 the family again asked him about the Coumadin. He stated he did not order the Coumadin. On 3/21/2016 the facility held a care conference for R1 and the family again questioned the Coumadin, asking RN-N about the medication. RN-N stated she would investigate why R1 was taking the medication. On 3/22/2016 the family observed R1 was more tired than usual. On 3/23/2016 the family visited and they were unable to wake the resident. The family alerted facility staff and asked them to call 911. R1 was transported to the hospital, and was diagnosed with a brain bleed. The resident had surgery (craniotomy) the next day to remove the blood. R1 is now recovering at another facility and he seems to be slowly getting better.</p> <p>The policy titled Prescriber Medication Orders, undated and provided by the facility revealed: Medications are administered only according to the clear, complete and signed order of a person lawfully authorized to prescribe. 1. Each medication order is documented in the resident's medical record with the date, times and signature of the person receiving the order. The order is recorded on the physician order sheet and the Medication Administration Record. (MAR).</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 7</p> <p>The policy Titled Putting in Medication Orders, undated and provided by the facility revealed under 7. e. ii. 1. If a HUC put the original order in a licensed nurse must verify the order prior to administration. a. EMAR will not allow administration of an order without it being verified.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could update appropriate policies, train staff on the updated policies, and monitor implementation of the new policies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21545		
21850	<p>MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac. Bill of Rights</p> <p>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 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.</p> <p>This MN Requirement is not met as evidenced by:</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	<p>Continued From page 8</p> <p>Based on interview and document review the facility failed to ensure each resident was free from neglect for 1 of 6 residents reviewed, Resident #1 (R1), when the resident was administered Coumadin (blood thinner) for 14 days, when he had no physician's order for Coumadin. R1 was hospitalized, and he developed a subdural bleed which required craniotomy treatment. Findings include:</p> <p>Medical record review revealed R1 was admitted to the facility on 3/2/2016 with diagnoses that included multiple fractures after having been struck by a car, and hypertension. R1's careplan dated 3/8/2016 revealed R1 required the assistance of one staff member with self care including bathing, dressing and grooming.</p> <p>R1's physician orders dated 3/2/2016 included Lovenox injection daily (blood thinner) 40 mg/o. 4 ml solution daily for 28 days. No physician order for Coumadin was found in R1's medical record.</p> <p>R1's Electronic Medication Administration Record (EMAR) was reviewed and revealed that R1 received Coumadin on 3/8/2016 - 3/21/2016, for a total of 14 doses over 14 days. 4 mg. on 3/8, 3/9, 3/10, 3/15, 3/16, and 3/17/2016. 7 mg. on 3/11, 3/12, 3/13, 3/14, 3/18, 3/19, 3/20, and 3/21/2016.</p> <p>R1's laboratory results dated 3/22/2016 collected at 7:30 a.m. revealed R1's INR was measured at 10.73 "High Critical" with the normal reference range being 0.90 - 1.10.</p> <p>R1's Resident Transfer Form, dated 3/23/2016 revealed R1 was sent to the hospital due to elevated INR, and the resident was lethargic and</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	<p>Continued From page 9</p> <p>less responsive.</p> <p>The resident ' s hospital record revealed the resident was admitted to the hospital on 3/23/2016 with diagnoses that included Subdural Hematoma (an accumulation of blood on the brain's surface beneath the skull.) The resident underwent a craniotomy for hematoma evacuation.</p> <p>An interview with Registered Nurse N (RN-N) was conducted on 3/31/2016 at 11:10 a.m. RN-N stated on 3/21/2016 care conference for R1 was conducted and during that conference R1's family questioned why he was taking Coumadin. RN-N stated she reviewed R1's chart and could find no order for Coumadin. RN-N then reported the concern to RN, Assistant Director of Nursing-B on 3/21/2016. RN-N stated ADON-B later told her that there was a valid order for the Coumadin from R1's Nurse Practitioner. RN-N stated on 3/22/2016 R1's Nurse Practitioner came in and RN-N asked her if there was an order for R1 to have Coumadin. No order for Coumadin was found. RN-N stated she was very concerned about the issue, because the Coumadin dose was quite high for someone who had not used Coumadin before.</p> <p>An interview with ADON-B was conducted on 3/30/2016 at 10:10 a.m. ADON-B stated RN-N asked him about R1's Coumadin order on 3/21/2016. ADON-B stated he looked in R1's EMAR and saw a valid order for Coumadin in the resident's orders. When asked if he looked at the written physicians orders to validate the order, he stated he did not, but looked in the computer, because each computer order is validated by a licensed nurse with the written physician's order. On 3/22/2016 R1's INR was drawn (a measure of</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	<p>Continued From page 10</p> <p>blood clotting) and was very high. ADON-B then compared R1's written physician's orders with what was in his EMAR and R1 had received numerous doses of Coumadin, for which he had no physician's order. Health Unit Coordinator I (HUC-I) entered the order and Licensed Practical Nurse H (LPN-H) verified the order. Nursing staff called R1's Nurse Practitioner who ordered oral Vitamin K. Later R1 became less responsive and was sent to the Emergency Department (ED) for treatment.</p> <p>An interview with HUC-I was conducted on 3/31/2016 at 2:00 p.m. HUC-I stated she recalled R1, but did not recall entering an order for Coumadin into the electronic medical record for him. HUC-I stated she reviewed the record and the record indicates she entered the order, and no other staff member could have used her name to enter the order. HUC-I stated the only explanation she has is that she must have entered another resident's Coumadin order into R1's EMAR.</p> <p>An interview with LPN-H was conducted on 4/1/2016 at 1:10 p.m. LPN-H stated she did not recall verifying the Coumadin order for R1, but her name was in the computer, so she must have done so. LPN-H had no explanation for the error except perhaps she made an error. No other staff member could have verified it, because they use passwords for all their computer work.</p> <p>An interview with R1's physician (MD-K) was conducted on 3/31/2016 at 10:22 a.m. and revealed she first learned of the medication error on 3/22/2016, when her Nurse Practitioner called to tell her that R1's INR was over 10. Initially R1 was asymptomatic and was given 5 mg Vitamin K orally. On 3/23/2016 he experienced mental</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	<p>Continued From page 11</p> <p>status changes and he was sent to the ED. MD-K stated no one from her office, including herself or any nurse practitioner, ordered Coumadin for R1.</p> <p>An interview was conducted with R1's family including 2 of his daughters and R1's wife on 4/7/2016 at 1:00 p.m. R1's family stated they initially questioned why R1 was getting Coumadin on 3/8/2016. LPN-H told them that R1's physician ordered the medication. When R1 saw his orthopedic doctor on 3/16/2016 the family again asked him about the Coumadin. He stated he did not order the Coumadin. On 3/21/2016 the facility held a care conference for R1 and the family again questioned the Coumadin, asking RN-N about the medication. RN-N stated she would investigate why R1 was taking the medication. On 3/22/2016 the family observed R1 was more tired than usual. On 3/23/2016 the family visited and they were unable to wake the resident. The family alerted facility staff and asked them to call 911. R1 was transported to the hospital, and was diagnosed with a brain bleed. The resident had surgery (craniotomy) the next day to remove the blood. R1 is now recovering at another facility and he seems to be slowly getting better.</p> <p>The policy titled Prescriber Medication Orders, undated and provided by the facility revealed: Medications are administered only according to the clear, complete and signed order of a person lawfully authorized to prescribe. 1. Each medication order is documented in the resident's medical record with the date, times and signature of the person receiving the order. The order is recorded on the physician order sheet and the Medication Administration Record. (MAR).</p> <p>The policy Titled Putting in Medication Orders, undated and provided by the facility revealed</p>	21850		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	<p>Continued From page 12</p> <p>under 7. e. ii. 1. If a HUC put the original order in a licensed nurse must verify the order prior to administration. a. EMAR will not allow administration of an order without it being verified.</p> <p>The policy titled Abuse Prevention Plan, dated revised 1/2015 was reviewed and revealed under Definitions: Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could update appropriate policies, train staff on the updated policies, and monitor implementation of the new policies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21850		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245310	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/11/2016
NAME OF FACILITY BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0333	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.25(m)(2)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	07/11/2016	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/6/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
---	--

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00940	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 7/11/2016
NAME OF FACILITY BENEDICTINE HEALTH CENTER INNSBRUCK	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21545	Correction	ID Prefix 21850	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.1320 A.B.C	Completed	Reg. # MN St. Statute 144.651 Subd. 14	Completed	Reg. #	Completed
LSC	07/11/2016	LSC	07/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/6/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		