DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Maranatha Care Center

Facility Address:
5409 69th Avenue North

Facility City:
Brooklyn Center

State: Minnesota | **ZIP:** 55429 | **County:** Hennepin

Report Number:
H5462061

Time of Visit:
8:00 a.m. to 5:30 p.m.
8:30 a.m. to 4:30 p.m.

Date of Visit:
July 26 and 27, 2017

Date Concluded:
September 7, 2017

Investigator's Name and Title:
Carrie Euerle, R.N., Special Investigator
Darlene Schwan, R.N., Special Investigator

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when facility staff administered the resident's antibiotics daily instead of every other day. The resident's condition declined and was send to the emergency room.

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

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

Conclusion:

Based on a preponderance of evidence, neglect occurred when staff incorrectly transcribed and administered the resident an incorrect dose of a prescribed antibiotic. The resident required treatment at the hospital due to an antibiotic overdose.

The resident was admitted to the facility with diagnoses which included left knee prosthesis, streptococcal sepsis, and pneumonia. The resident's cognition was intact, however the resident required staff assistance for activities of daily living. On admission to the facility, the resident had physician's orders for intravenous (IV) and oral antibiotics due to a left knee infection. After completion of these antibiotics, the resident's physician changed the antibiotic order to Levaquin 750 mg every day, one time per day, by mouth for 6 months. One month later, due to side effects from the antibiotic, the nurse practitioner changed the resident's antibiotic order to Levaquin 750 mg one tablet every other day for six months.

Seven days after the antibiotic order was changed from daily to every other day, the resident's nurse practitioner was updated due to the resident's complaints of shaking and quivering mouth movements. During a review of the resident's medications, the nurse practitioner discovered the resident's antibiotic

was transcribed incorrectly in the resident's electronic record and staff had administered the Levoquin 750mg incorrectly.

The resident received Levaquin 750 mg six times per day every other day for three days, for a total of 18 doses over a six day period. The nurse practitioner discussed this error with the pharmacist who suggested the nurse practitioner should contact poison control due to an overdose. Poison control was called and the resident was then sent to the emergency room.

The resident was treated with intravenous fluids to flush out the antibiotic due to the antibiotic overdose and returned to the facility later that evening with orders to hold the medication for 48 hours. The resident was later prescribed a different antibiotic to treat his/her infection.

When interviewed, the resident confirmed s/he recalled the medication error and stated "it was awful" and now "questions every medication that is given" to him/her. The resident could not recall the details of the medication error, but knew s/he was "given too much" of the medication and could not recall if s/he was treated in the hospital.

When interviewed, the nurse practitioner confirmed s/he was the person who identified the medication error. The NP stated s/he was told by the facility that the error occurred due to a transcription error, however felt that staff who administered the medication should have questioned the amount and frequency of the medication prior to administration of the medication.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation

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

Mitigating Factors:

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Although the facility had policies and procedures in place to prevent medication transcription and administration errors, the transcription and medication error still occurred. The medication order was double checked by facility staff, however entered incorrectly. Over a six day period, five different staff members administered the medication without question of the dose or frequency of the medication.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services

for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:
Deficiencies and state licensing orders were issued related to significant medication errors, reporting, and maltreatment.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

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

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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

Specify: _____

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

○ Yes ◉ No ○ N/A

Specify: Discharged

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact reporter, 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: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Seven

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Medication Pass
- [x] Facility Tour

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Brooklyn Center Police Department

Brooklyn Center City Attorney

Hennepin County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	R-C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification Revisit (PCR) was completed, to follow up on deficiencies issued related to complaint #H5462061. Maranatha Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 1, 2017

Ms. Alana Nelson, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number H5462061

Dear Ms. Nelson:

On September 14, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 19, 2017. (42 CFR 488.422)

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

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

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on August 16, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 5, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on August 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 24, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on August 16, 2017, as of September 24, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 24, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of September 14, 2017:

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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	00226	A. BUILDING: _____ B. WING _____	R-C 10/05/2017

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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 licensing order follow up was completed, to follow up on correction orders issued related to complaint #H5460261. Maranatha Care Center was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 1, 2017

Ms. Alana Nelson, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

Re: Enclosed Reinspection Results - Complaint Number H5462061

Dear Ms. Nelson:

On September 5, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on August 16, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5462061. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		

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

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F 225	Continued From page 1 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (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 interview and document review the facility failed to report allegations of neglect to the State Agency (SA) related to significant medication errors for 2 of 3 residents (R1, R2)	F 225		

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F 225	Continued From page 2 reviewed for medication errors. Findings include: R1's medical record was reviewed and included R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 admitted with physician's orders dated March 2017 for intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician's orders indicated the physician changed her antibiotic order on 4/26/17 to Levaquin 750 mg every day, one time per day by mouth for 6 months. Physician's orders dated 5/24/17, indicated R1's antibiotic order was changed to Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17. On 5/31/17 R1's Nurse Practitioner (NP) reviewed R1's medical record and discovered R1's Levaquin 750mg was transcribed and administered incorrectly over the last six days between 5/26/17-5/31/17. R1's MAR indicated R1 recieved the medication six times per day every other day for three days instead of the ordered Levaquin 750 mg one time per day every other	F 225		

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F 225	Continued From page 3	F 225		

day. The NP consulted with the pharmacist and physician. The NP then called poison control and had R1 sent to the emergency room for an evaluation. The NP informed the facility of the discovered transcription error.

Hospital records dated 5/31/17 indicated R1 was treated for an overdose of antibiotic, accidental or unintentional and intravenous (IV) fluids and an antiemetic medication was administered at the hospital. R1 returned to the facility the same evening with physician orders to hold the Levaquin for 48 hours.

R1's progress note dated 5/31/17 at 9:13 p.m. indicated a call was placed to the hospital to check the status of R1. The hospital nurse indicated R1 would discharge back to the facility later that night and Levaquin was flushed out of R1's system at the hospital and new orders would include to hold the Levaquin for 48 hours.

A progress noted dated 6/1/17 at 1:27 a.m. indicated R1 retured from the hospital before midnight.

A facility Medication Variance Report dated 6/8/17 indicated a transcription error occurred between 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin 750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant".

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F 225	Continued From page 4 On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by five different staff members. Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's medication was transcribed incorrectly and administered incorrectly by staff and the error was not reported to the SA. The DON confirmed she identified the medication error on 6/1/17 when informed by the NP of the error. The DON signed R1's Medication Variance report 6/8/17 and indicated the error as a significant error due because the medication was an antibiotic and R1 had to be treated at the hospital for an antibiotic overdose. According to facility policy, the error should have been reported. R2 Reveiw of R2's medical record identified R1 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. R2's physician's orders dated November 2016 identified R2 had physician orders for profilactic medication for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for lung infection. The November 2016 physician orders indicated the medication was due in January 2017. R2 had further November 2016 physician's orders for another profilactic antibiotic for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for lung infection.	F 225		

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F 225	Continued From page 5 The physician orders indicated the next round of the antibiotic was due in February 2017. R2's January 2017 and February 2017 MAR indicated R2 recieved the medication as prescribed. R2's MAR for March 2017 and April 2017 indicated R2 did not recieve the prescribed 10 days of Doxycycline Hydrochloride for March 2017 or the prescribed 10 days of the Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March and April. The report indicated this was a significant medication error. R2's March 2017 and April 2017 progress notes indicated R2 did not have noted side effects from missing the March and April 2017 prescribed antibiotic doses. R2's May 2017 progress notes indicated R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an infection control log. The DON stated she identified R2's medication error as significant as it may have caused actual harm and indicated she did not report the medication error, although it was facility policy to report significant	F 225		

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	245462	A. BUILDING _____ B. WING _____	C 08/16/2017

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MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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F 225	Continued From page 6 medication errors. A facility Vulnerable Adult Abuse Prevention Plan Policy dated April 2017 identified under examples of medical neglect "not taking action on medical problems, prescribed treatment or therapies" and under potential indicators of neglect "signs of excess drugging, lack of medication, or othe misuse" of medication. The policy further indicated all allegations of maltreatment against a vulnerable	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident	F 226		

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F 226	Continued From page 7 property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their policy and report allegations of neglect to the State Agency (SA) related to significant medication errors for 2 of 3 residents (R1, R2) reviewed for medication errors. Findings include: A facility Vulnerable Adult Abuse Prevention Plan Policy dated April 2017 identified under examples of medical neglect "not taking action on medical problems, prescribed treatment or therapies" and under potential indicators of neglect "signs of excess drugging, lack of medication, or othe misuse" of medication. The policy further indicated all allegations of maltreatment against a vulnerable adult would immediately be reported to the state agency. R1's medical record was reviewed and R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 admitted with physician's orders dated March 2017 for intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician's orders indicated the physician changed her antibiotic order on 4/26/17	F 226		

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F 226	Continued From page 8 to Levaquin 750 mg every day, one time per day by mouth for 6 months. On 5/24/17, R1's physician's orders indicated that R1's antibiotic order was changed to Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17. A facility Medication Variance Report dated 6/8/17 indicated a transcription error occurred between 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin 750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant". On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by five different staff members. Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's	F 226		

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F 226	Continued From page 9 medication was transcribed incorrectly and administered incorrectly by staff and the error was not reported to the SA. The DON confirmed she identified the medication error on 6/1/17 when informed by the NP of the error. The DON signed R1's Medication Variance report and indicated the error as a significant error due to the medication on 6/8/17 and indicated this was because the medication was an antibiotic and R1 had to be treated at the hospital for an antibiotic overdose and according to facility policy, the error should have been reported. R2 Reveiw of R2's medical record identified R1 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. Review of R2's physician's orders dated November 2016 identified R2 had physician orders for profilactic medication for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for lung infection. The November 2016 physician orders indicated the medication was due in January 2017. R2 had further November 2016 physician's orders for another profilactic antibiotic for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for lung infection. The physician orders indicated the next round of the antibiotic was due in February 2017. Review of R2's January 2017 and February 2017 MAR confirmed R2 recieved the medication as prescribed.	F 226		

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F 226	Continued From page 10 R2's MAR for March 2017 and April 2017 were reviewed and indicated R2 did not recieve the prescribed 10 days of Doxycycline Hydrochloride for March 2017 or the prescribed 10 days of the Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March 2017 and April 2017. The report indicated this was a significant medication error. R2's March 2017 and April 2017 progress notes indicated R2 did not have noted side effects from missing the March and April 2017 prescribed antibiotic doses. Further review of R2's May 2017 progress notes indicated R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an infection control log. The DON stated she identified R2's medication error as significant as it may have caused actual harm and indicated she did not report the medication error, although it was facility policy to report significant medication errors.	F 226		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors.	F 333		

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F 333	Continued From page 11 The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 3 residents (R1, R2) reviewed were free of significant medication errors when R1's antibiotic was transcribed and administered incorrectly. Harm occurred when R1 needed treatment at the hospital for an antibiotic overdose. Additionally, R2's antibiotic orders were transcribed incorrectly and R2 missed two months of the prescribed antibiotic. Findings include: R1's medical record included R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 was cognitively intact and admitted with physician's orders for intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician changed her antibiotic order on 4/26/17 to Levaquin 750 mg every day, one time per day by mouth for 6 months. Review of R1's physician's orders indicated on 5/24/17 that R1's antibiotic order was changed to Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every	F 333		

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F 333	Continued From page 12 other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17. Review of R1's progress note dated 5/29/17 at 12:04 p.m. indicated R1 "verbalied she had shaking on her upper extremities last night" and mentioned to staff she thought she was having a "stroke". Facility staff documented R1's vital signs, which were within normal limits. No shaking was observed by staff. Staff observed R1 had equal hand grasps, no shortness of breath, was alert and had no changes in mentation and R1's blood sugar was within normal limits. An on-call nurse practitioner was updated who directed staff to continue to monitor R1's condition. A progress note dated 5/29/17 at 10:15 p.m. indicated R1 had an emesis after dinner at 5:00 p.m. R1 indicated to staff she felt better after the emesis and staff noted they would continue to monitor R1. A progress note dated 5/30/17 at 9:25 p.m. indicated R1's appetite and fluid intake was low due to complaints of nausea. The note further indicated R1 had a small emesis in the evening and R1's blood pressure was low, however other vital signs were within normal range. R1 requested to speak with the nurse practitioner the following morning. A progress note dated 5/31/17 at 5:51 a.m. indicated R1 was "needy with cares" and "observed to be anxious" and staff indicated they would continue to monitor R1.	F 333		

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F 333	Continued From page 13 On 5/31/17 R1's Nurse Practitioner (NP) reviewed R1's medical record and discovered R1's Levaquin 750mg was transcribed and administered incorrectly over the last six days from 5/26/17-5/31/17. R1's MAR indicated R1 recieved the medication six times per day every other day for three days instead of the order of Levaquin 750 mg one time per day every other day. The NP consulted with the pharmacist and physician. The NP then called poison control and had R1 sent to the emergency room for an evaluation. R1's progress note dated 5/31/17 at 9:13 p.m. indicated a call was placed to the hospital to check the status of R1. The hospital nurse indicated R1 would discharge back to the facility later that night and Levaquin was flushed out of R1's system at the hospital and new orders would include to hold the Levaquin for 48 hours. Hospital records dated 5/31/17 indicated R1 was treated for an overdose of antibiotic, accidental or unintentional and intravenous (IV) fluids were administered at the hospital. R1 returned to the facility the same evening with physician's orders to hold the Levaquin for 48 hours. A progress noted dated 6/1/17 at 1:27 a.m. indicated R1 returned from the hospital before midnight. A facility Medication Variance Report dated 6/8/17 indicated a transcription error occurred on 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was	F 333		

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F 333	Continued From page 14 entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant". On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by 5 different staff members. Interview with the Health Unit Coordinator (HUC)-A on 7/27/17 at 10:40 a.m. indicated she had entered R1's physician order for Levoquin 750 mg and did not realize she had checked the box that indicated the medication was to be given six times per day. HUC-A stated she "must have read the order wrong". HUC-A indicated this error should have also been caught on the second check of the medication by the nurse prior to the order being changed on R1's MAR and medical record. Interview the Registered Nurse (RN)-B on 7/27/17 at 12:20 p.m. indicated he was the nurse manager on R1's unit. RN-B confirmed his name was indicated on R1's electronic orders indicated he had second checked the orders in the computer prior to the orders being changed on the MAR and in R1's electronic medical record. RN-B stated he had observed the orders were not signed off in the computer, however were signed off as double checked in R1's paper chart and he then signed off on the orders in the computer. RN-B admitted he did not check to see the frequency of the time of administration of the medication under the physician's order on the MAR. RN-B stated he should have checked the	F 333		

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F 333	Continued From page 15 entire order before signing off on the order. Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's medication was transcribed incorrectly and administered incorrectly by staff. The DON confirmed she identifed the medication error as a significant error due to the medication being an antibiotic and R1 having to be treated at the hospital for an antibiotic overdose. The DON stated the HUC and RN-B who transcribed R1's Levoquin order had been re-educated and retrained. The DON stated LPN-A no longer worked at the facility when the medication error was discovered. The DON could not indicate why the medication error report was filled out on 6/8/17 and not on 5/31/17 when the medication error was discovered. The DON futher stated she expected all staff who enter physician's orders to follow facility policy and check the order in its entirety before signing off on physician orders. Interview with R1 on 8/2/17 at 11:02 a.m. confirmed she recalled the medication error. R1 stated "it was awful" and now "questions every medication that is given to her". R1 could not recall the details of the medication error, but knew she was "given too much" of the medication and could not recall if she was treated in the hospital. Interview with the licensed practical nurse (LPN)-A on 8/3/17 at 11:14 a.m. who had signed off on the second check of R1's paper physician orders for Levoquin 750 mg on 5/26/17, indicated she was not aware of a medication error regarding R1's Levoquin as she no longer worked at the facility.	F 333		

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F 333	Continued From page 16 Interview with the Nurse Practitioner (NP) on 8/4/17 at 1:41 p.m. confirmed she found the medication error after being informed of R1's complaints of shaking and quivering mouth movements. The NP was doing a medication review of R1's prescribed medication when she discovered the error. The NP stated she discussed the medication error with the pharmacist who directed her to call poison control and have R1 sent to the emergency room (ER) for an evaluation. The NP stated she was told by the facility it was a transcription error, however felt that staff administering the medication should have questioned the amount and frequency of the medication being given. R2 Review of R2's medical record included R2 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. R2 admitted to the facility with physician orders dated November 2016 for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for profolactic treatment of lung infection. The November 2016 physician orders indicated the medication was due in January. R2 had further physician's orders dated November 2016 for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for profolactic treatment lung infection. The physician orders indicated the next round of the antibiotic was due in February. R2's MAR for March 2017 and April 2017	F 333		

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F 333	Continued From page 17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of profalactic antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March and April. The report indicated this was a significant medication error. R2's medical record indicated R2 did not have noted side effects from missing the March 2017 and April 2017 prescribed antibiotic doses. R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an infection control log. The DON further stated she discussed the error with the staff who entered the error and held an all staff meeting on input of physician orders and transcription of orders. The DON further confirmed she expected staff to enter orders correctly per facility policy and if the order was difficult to ask another staff member or herself about the order prior to entering it in the computer. A facility policy provided entitled Medication Administration Error Policy dated August 2015 · indicated medications not prepared or administered in accordance with prescribers	F 333		

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F 333	Continued From page 18 orders, manufacturer's specifications, or accepted professional standard and practice regulations is defined as a medication error. The policy further indicated a significant medication error means one which causes the resident discomfort or jeapordizes his/her health and safety. The policy included criteria for determining significance of medication error included resident condition, drug category and frequency of the error.	F 333		

Electronically delivered

September 14, 2017

Ms. Alana Nelson, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number H5462061

Dear Ms. Nelson:

On August 16, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567 and/or Form A, whereby significant corrections are required.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

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

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

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

- State Monitoring effective September 19, 2017. (42 CFR 488.422)

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 16, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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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 #H5432061. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		

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21545	Continued From page 2 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 3 residents (R1, R2) reviewed were free of significant medication errors when R1's antibiotic was transcribed and administered incorrectly. Harm occurred when R1 was treated at the hospital for an antibiotic overdose. Additionally, R2's antibiotic orders were transcribed incorrectly and R2 missed two months of the prescribed antibiotic. Findings include: R1's medical record included R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 was cognitively intact and admitted with physician's orders for	21545		

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21545	Continued From page 3 intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician changed her antibiotic order on 4/26/17 to Levaquin 750 mg every day, one time per day by mouth for 6 months. Review of R1's physician's orders indicated on 5/24/17 that R1's antibiotic order was changed to Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17. Review of R1's progress note dated 5/29/17 at 12:04 p.m. indicated R1 "verbalied she had shaking on her upper extremities last night" and mentioned to staff she thought she was having a "stroke". Facility staff documented R1's vital signs, which were within normal limits. No shaking was observed by staff. Staff observed R1 had equal hand grasps, no shortness of breath, was alert and had no changes in mentation and R1's blood sugar was within normal limits. An on-call nurse practitioner was updated who directed staff to continue to monitor R1's condition. A progress note dated 5/29/17 at 10:15 p.m. indicated R1 had an emesis after dinner at 5:00 p.m. R1 indicated to staff she felt better after the emesis and staff noted they would continue to monitor R1.	21545		

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21545	Continued From page 4 A progress note dated 5/30/17 at 9:25 p.m. indicated R1's appetite and fluid intake was low due to complaints of nausea. The note further indicated R1 had a small emesis in the evening and R1's blood pressure was low, however other vital signs were within normal range. R1 requested to speak with the nurse practitioner the following morning. A progress note dated 5/31/17 at 5:51 a.m. indicated R1 was "needy with cares" and "observed to be anxious" and staff indicated they would continue to monitor R1. An interview with the Nurse Practitioner on 8/4/17 at 1:41 p.m. confirmed that on 5/31/17 during review of R1's medical record, she discovered R1's Levaquin 750mg was transcribed and administered incorrectly over the last six days from 5/26/17-5/31/17. R1's MAR indicated R1 recieved the medication six times per day every other day for three days instead of the order of Levaquin 750 mg one time per day every other day. The NP consulted with the pharmacist and physician. The NP then called poison control and had R1 sent to the emergency room for an evaluation. Hospital records dated 5/31/17 indicated R1 was treated for an overdose of antibiotic, accidental or unintentional and intravenous (IV) fluids were administered at the hospital. R1 returned to the facility the same evening with physician's orders to hold the Levaquin for 48 hours. R1's progress note dated 5/31/17 at 9:13 p.m. indicated a call was placed to the hospital to check the status of R1. The hospital nurse indicated R1 would discharge back to the facility	21545		

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21545	Continued From page 5 later that night and Levaquin was flushed out of R1's system at the hospital and new orders would include to hold the Levaquin for 48 hours. A progress noted dated 6/1/17 at 1:27 a.m. indicated R1 returned from the hospital before midnight. A facility Medication Variance Report dated 6/8/17 indicated a transcription error occurred on 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant". On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by 5 different staff members. Interview with the Health Unit Coordinator (HUC)-A on 7/27/17 at 10:40 a.m. indicated she had entered R1's physician order for Levoquin 750 mg and did not realize she had checked the box that indicated the medication was to be given six times per day. HUC-A stated she "must have read the order wrong". HUC-A indicated this error should have also been caught on the second check of the medication by the nurse prior to the order being changed on R1's MAR and medical record. Interview the Registered Nurse (RN)-B on 7/27/17 at 12:20 p.m. indicated he was the nurse	21545		

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21545	Continued From page 6	21545		

manager on R1's unit. RN-B confirmed his name was indicated on R1's electronic orders indicated he had second checked the orders in the computer prior to the orders being changed on the MAR and in R1's electronic medical record. RN-B stated he had observed the orders were not signed off in the computer, however were signed off as double checked in R1's paper chart and he then signed off on the orders in the computer. RN-B admitted he did not check to see the frequency of the time of administration of the medication under the physician's order on the MAR. RN-B stated he should have checked the entire order before signing off on the order.

Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's medication was transcribed incorrectly and administered incorrectly by staff. The DON confirmed she identifed the medication error as a significant error due to the medication being an antibiotic and R1 having to be treated at the hospital for an antibiotic overdose. The DON stated the HUC and RN-B who transcribed R1's Levoquin order had been re-educated and retrained. The DON stated LPN-A no longer worked at the facility when the medication error was discovered. The DON could not indicate why the medication error report was filled out on 6/8/17 and not on 5/31/17 when the medication error was discovered. The DON futher stated she expected all staff who enter physician's orders to follow facility policy and check the order in its entirety before signing off on physician orders.

Interview with R1 on 8/2/17 at 11:02 a.m. confirmed she recalled the medication error. R1 stated "it was awful" and now "questions every medication that is given to her". R1 could not

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21545	Continued From page 7 recall the details of the medication error, but knew she was "given too much" of the medication and could not recall if she was treated in the hospital. Interview with the licensed practical nurse (LPN)-A on 8/3/17 at 11:14 a.m. who had signed off on the second check of R1's paper physician orders for Levoquin 750 mg on 5/26/17, indicated she was not aware of a medication error regarding R1's Levoquin as she no longer worked at the facility. Interview with the Nurse Practitioner (NP) on 8/4/17 at 1:41 p.m. confirmed she found the medication error after being informed of R1's complaints of shaking and quivering mouth movements. The NP was doing a medication review of R1's prescribed medication when she discovered the error. The NP stated she discussed the medication error with the pharmacist who directed her to call poison control and have R1 sent to the emergency room (ER) for an evaluation. The NP stated she was told by the facility it was a transcription error, however felt that staff administering the medication should have questioned the amount and frequency of the medication being given. R2 Review of R2's medical record included R2 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. R2 admitted to the facility with physician orders for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for profolactic treatment of lung infection. The	21545		

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21545	Continued From page 8 physician orders indicated the medication was due in January. R2 had further physician's orders for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for profolactic treatment lung infection. The physician orders indicated the next round of the antibiotic was due in February. R2's MAR for March 2017 and April 2017 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of profalactic antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March and April. The report indicated this was a significant medication error. R2's medical record indicated R2 did not have noted side effects from missing the March 2017 and April 2017 prescribed antibiotic doses. R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an infection control log. The DON further stated she discussed the error with the staff who entered the error and held an all staff meeting on input of physician orders and transcription of orders. The DON further confirmed she expected staff to	21545		

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21545	Continued From page 9 enter orders correctly per facility policy and if the order was difficult to ask another staff member or herself about the order prior to entering it in the computer. A facility policy provided entitled Medication Administration Error Policy dated August 2015 indicated medications not prepared or administered in accordance with prescribers orders, manufacturer's specifications, or accepted professional standard and practice regulations is defined as a medication error. The policy further indicated a significant medication error means one which causes the resident discomfort or jeapordizes his/her health and safety. The policy included criteria for determining significance of medication error included resident condition, drug category and frequency of the error. SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders. TIME PERIOD TO CORRECT: Twenty-one (21) days	21545		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment.	21850		

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	00226	A. BUILDING: _____ B. WING _____	C 08/16/2017

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21850	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on document review and interviews the facility failed to ensure 1 of 3 residents (R1) reviewed was free from maltreatment when R1 when staff incorrectly administered a prescribed antibiotic. R1 required emergency room treatment due to an antibiotic overdose. Findings include: R1's medical record included R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 was cognitively intact and admitted with physician's orders for intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician changed her antibiotic order on 4/26/17 to Levaquin 750 mg every day, one time per day by mouth for 6 months. Review of R1's physician's orders indicated on 5/24/17 that R1's antibiotic order was changed to	21850		

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21850	Continued From page 11 Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17. Review of R1's progress note dated 5/29/17 at 12:04 p.m. indicated R1 "verbalied she had shaking on her upper extremities last night" and mentioned to staff she thought she was having a "stroke". Facility staff documented R1's vital signs, which were within normal limits. No shaking was observed by staff. Staff observed R1 had equal hand grasps, no shortness of breath, was alert and had no changes in mentation and R1's blood sugar was within normal limits. An on-call nurse practitioner was updated who directed staff to continue to monitor R1's condition. A progress note dated 5/29/17 at 10:15 p.m. indicated R1 had an emesis after dinner at 5:00 p.m. R1 indicated to staff she felt better after the emesis and staff noted they would continue to monitor R1. A progress note dated 5/30/17 at 9:25 p.m. indicated R1's appetite and fluid intake was low due to complaints of nausea. The note further indicated R1 had a small emesis in the evening and R1's blood pressure was low, however other vital signs were within normal range. R1 requested to speak with the nurse practitioner the	21850		

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21850	Continued From page 12 following morning. A progress note dated 5/31/17 at 5:51 a.m. indicated R1 was "needy with cares" and "observed to be anxious" and staff indicated they would continue to monitor R1. On 5/31/17 R1's Nurse Practitioner (NP) reviewed R1's medical record and discovered R1's Levaquin 750mg was transcribed and administered incorrectly over the last six days from 5/26/17-5/31/17. R1's MAR indicated R1 recieved the medication six times per day every other day for three days instead of the order of Levaquin 750 mg one time per day every other day. The NP consulted with the pharmacist and physician. The NP then called poison control and had R1 sent to the emergency room for an evaluation. R1's progress note dated 5/31/17 at 9:13 p.m. indicated a call was placed to the hospital to check the status of R1. The hospital nurse indicated R1 would discharge back to the facility later that night and Levaquin was flushed out of R1's system at the hospital and new orders would include to hold the Levaquin for 48 hours. Hospital records dated 5/31/17 indicated R1 was treated for an overdose of antibiotic, accidental or unintentional and intravenous (IV) fluids were administered at the hospital. R1 returned to the facility the same evening with physician's orders to hold the Levaquin for 48 hours. A progress noted dated 6/1/17 at 1:27 a.m. indicated R1 returned from the hospital before midnight. A facility Medication Variance Report dated 6/8/17	21850		

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21850	Continued From page 13 indicated a transcription error occurred on 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant". On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by 5 different staff members. Interview with the Health Unit Coordinator (HUC)-A on 7/27/17 at 10:40 a.m. indicated she had entered R1's physician order for Levoquin 750 mg and did not realize she had checked the box that indicated the medication was to be given six times per day. HUC-A stated she "must have read the order wrong". HUC-A indicated this error should have also been caught on the second check of the medication by the nurse prior to the order being changed on R1's MAR and medical record. Interview the Registered Nurse (RN)-B on 7/27/17 at 12:20 p.m. indicated he was the nurse manager on R1's unit. RN-B confirmed his name was indicated on R1's electronic orders indicated he had second checked the orders in the computer prior to the orders being changed on the MAR and in R1's electronic medical record. RN-B stated he had observed the orders were not signed off in the computer, however were signed off as double checked in R1's paper chart and he then signed off on the orders in the computer.	21850		

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21850	Continued From page 14 RN-B admitted he did not check to see the frequency of the time of administration of the medication under the physician's order on the MAR. RN-B stated he should have checked the entire order before signing off on the order. Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's medication was transcribed incorrectly and administered incorrectly by staff. The DON confirmed she identifed the medication error as a significant error due to the medication being an antibiotic and R1 having to be treated at the hospital for an antibiotic overdose. The DON stated the HUC and RN-B who transcribed R1's Levoquin order had been re-educated and retrained. The DON stated LPN-A no longer worked at the facility when the medication error was discovered. The DON could not indicate why the medication error report was filled out on 6/8/17 and not on 5/31/17 when the medication error was discovered. The DON futher stated she expected all staff who enter physician's orders to follow facility policy and check the order in its entirety before signing off on physician orders. Interview with R1 on 8/2/17 at 11:02 a.m. confirmed she recalled the medication error. R1 stated "it was awful" and now "questions every medication that is given to her". R1 could not recall the details of the medication error, but knew she was "given too much" of the medication and could not recall if she was treated in the hospital. Interview with the licensed practical nurse (LPN)-A on 8/3/17 at 11:14 a.m. who had signed off on the second check of R1's paper physician orders for Levoquin 750 mg on 5/26/17, indicated she was not aware of a medication error	21850		

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21850	Continued From page 15 regarding R1's Levoquin as she no longer worked at the facility. Interview with the Nurse Practitioner (NP) on 8/4/17 at 1:41 p.m. confirmed she found the medication error after being informed of R1's complaints of shaking and quivering mouth movements. The NP was doing a medication review of R1's prescribed medication when she discovered the error. The NP stated she discussed the medication error with the pharmacist who directed her to call poison control and have R1 sent to the emergency room (ER) for an evaluation. The NP stated she was told by the facility it was a transcription error, however felt that staff administering the medication should have questioned the amount and frequency of the medication being given. R2 Review of R2's medical record included R2 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. R2 admitted to the facility with physician orders dated November 2016 for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for profolactic treatment of lung infection. The November 2016 physician orders indicated the medication was due in January. R2 had further physician's orders dated November 2016 for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for profolactic treatment lung infection. The physician orders indicated the next round of the antibiotic was due in February.	21850		

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21850	Continued From page 16 R2's MAR for March 2017 and April 2017 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of profalactic antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March and April. The report indicated this was a significant medication error. R2's medical record indicated R2 did not have noted side effects from missing the March 2017 and April 2017 prescribed antibiotic doses. R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an infection control log. The DON further stated she discussed the error with the staff who entered the error and held an all staff meeting on input of physician orders and transcription of orders. The DON further confirmed she expected staff to enter orders correctly per facility policy and if the order was difficult to ask another staff member or herself about the order prior to entering it in the computer. A facility policy provided entitled Medication Administration Error Policy dated August 2015 indicated medications not prepared or	21850		

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21850	Continued From page 17 administered in accordance with prescribers orders, manufacturer's specifications, or accepted professional standard and practice regulations is defined as a medication error. The policy further indicated a significant medication error means one which causes the resident discomfort or jeapordizes his/her health and safety. The policy included criteria for determining significance of medication error included resident condition, drug category and frequency of the error. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could educate involved staff on the importance of following the current policy and procedure for transcribing medication, and on the importance of following physician orders. The administrator or designee could educate staff on the abuse/neglect prevention policy and procedure and audit staff compliance regarding staff response to following facility policy and physician orders. The DON could report the findings to the quality assurance committee. TIME PERIOD TO CORRECT: Twenty-one (21) days	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		

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21980	Continued From page 18 individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of	21980		

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21980	Continued From page 19 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of neglect to the State Agency (SA)related to significant medication errors for 2 of 3 residents (R1, R2) reviewed for medication errors. Findings include: R1's medical record was reviewed and included R1 was admitted to the facility with diagnoses which included infection of the left knee prosthesis, streptococcal sepsis and pneumonia. R1 admitted with physician's orders dated March 2017 for intervenous (IV) and oral antibiotics due to an infection. After completion of these antibiotics, R1's physician's orders indicated the physician changed her antibiotic order on 4/26/17 to Levaquin 750 mg every day, one time per day by mouth for 6 months. Physician's orders dated 5/24/17, indicated R1's antibiotic order was changed to Levaquin 750 mg one tablet every other day for six months for left knee infection due to side effects of previously ordered antibiotic. R1's May 2017 Medication Administration Record (MAR) indicated R1's Levaquin 750 mg was transcribed as Levaquin 750 mg one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750mg six times per day every other day for three days for a total of 18 doses over a six day period from 5/26/17-5/31/17.	21980		

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21980	Continued From page 20 On 5/31/17 R1's Nurse Practitioner (NP) reviewed R1's medical record and discovered R1's Levaquin 750mg was transcribed and administered incorrectly over the last six days between 5/26/17-5/31/17. R1's MAR indicated R1 recieved the medication six times per day every other day for three days instead of the ordered Levaquin 750 mg one time per day every other day. The NP consulted with the pharmacist and physician. The NP then called poison control and had R1 sent to the emergency room for an evaluation. The NP informed the facility of the discovered transcription error. Hospital records dated 5/31/17 indicated R1 was treated for an overdose of antibiotic, accidental or unintentional and intravenous (IV) fluids and an antiemetic medication was administered at the hospital. R1 returned to the facility the same evening with physician orders to hold the Levaquin for 48 hours. R1's progress note dated 5/31/17 at 9:13 p.m. indicated a call was placed to the hospital to check the status of R1. The hospital nurse indicated R1 would discharge back to the facility later that night and Levaquin was flushed out of R1's system at the hospital and new orders would include to hold the Levaquin for 48 hours. A progress noted dated 6/1/17 at 1:27 a.m. indicated R1 retured from the hospital before midnight. A facility Medication Variance Report dated 6/8/17 indicated a transcription error occurred between 5/26/17 and was noted on 6/1/17 regarding R1's Levaquin 750 mg physician's order which was entered on R1's MAR as Levaquin 750 mg every other day six times per day. The order was	21980		

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21980	Continued From page 21 entered by the Health Unit Coordinator (HUC) and double checked by a nurse, per facility policy, however the error was not caught and the medication was administered incorrectly over a period of six days. The report included that the medication error was "significant". On 7/27/2017, R1's May 2017 MAR was reviewed and indicated Levaquin 750 mg was administered six times per day on 5/26/17, 5/28/17, and 5/30/17 to R1 for a total of 18 doses and administered by five different staff members. Interview with the Director of Nursing (DON) on 7/27/17 at 1:45 p.m. confirmed the R1's medication was transcribed incorrectly and administered incorrectly by staff and the error was not reported to the SA. The DON confirmed she identified the medication error on 6/1/17 when informed by the NP of the error. The DON signed R1's Medication Variance report 6/8/17 and indicated the error as a significant error due because the medication was an antibiotic and R1 had to be treated at the hospital for an antibiotic overdose. According to facility policy, the error should have been reported. R2 Reveiw of R2's medical record identified R1 was admitted to the facility with diagnoses which included Alzheimer's disease, bronchiectasis (a condition where the bronchial tubes of the lungs are scarred and damaged), and dementia. R2's physician's orders dated November 2016 identified R2 had physician orders for profilactic medication for Doxycycline Hydrochloride (an antibiotic) 100 milligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for lung infection. The November 2016 physician orders indicated the medication	21980		

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21980	Continued From page 22 was due in January 2017. R2 had further November 2016 physician's orders for another profilactic antibiotic for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg one tab one time per day for the first 10 days of every third month for lung infection. The physician orders indicated the next round of the antibiotic was due in February 2017. R2's January 2017 and February 2017 MAR indicated R2 recieved the medication as prescribed. R2's MAR for March 2017 and April 2017 indicated R2 did not recieve the prescribed 10 days of Doxycycline Hydrochloride for March 2017 or the prescribed 10 days of the Sulfamethoxazone/Trimethoprim for April 2017, for a total of 20 missed doses of antibiotics. A Medication Variance Report dated 5/4/17 indicated R2 did not recieve the prescribed Doxycycline Hydrochloride for March 2017 or the prescribed Sulfamethoxazone/Trimethoprim for April 2017. The report indicated staff did not input the antibiotic correctly in the specific months leading to the missing doses for March and April. The report indicated this was a significant medication error. R2's March 2017 and April 2017 progress notes indicated R2 did not have noted side effects from missing the March and April 2017 prescribed antibiotic doses. R2's May 2017 progress notes indicated R2 passed away on 5/27/2017 from end stage Alzheimer's Disease. Interview with the DON on 7/27/17 at 1:45 p.m. confirmed she had found R2's medication errors when reviewing monthly antibiotics for an	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	C 08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
21980	Continued From page 23 infection control log. The DON stated she identified R2's medication error as significant as it may have caused actual harm and indicated she did not report the medication error, although it was facility policy to report significant medication errors. A facility Vulnerable Adult Abuse Prevention Plan Policy dated April 2017 identified under examples of medical neglect "not taking action on medical problems, prescribed treatment or therapies" and under potential indicators of neglect "signs of excess drugging, lack of medication, or othe misuse" of medication. The policy further indicated all allegations of maltreatment against a vulnerable SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee (s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, or designee (s) could monitor to assure all reports of abuse and or neglect are being reported as directed by the policy. TIME PERIOD TO CORRECT: Twenty-one (21) days	21980		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 14, 2017

Ms. Alana Nelson, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

Re: Enclosed State Nursing Home Licensing Orders - Complaint Number H5462061

Dear Ms. Nelson:

A complaint investigation was completed on August 16, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulations Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

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

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

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

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)
cc: Licensing and Certification File
Home Care & Assisted Living File