DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name:			Report Number:	Date of Visit:			
Maranatha Care Ce			H5462061	July 26 and 27, 2017			
Facility Address: 5409 69th Avenue North Facility City:		Time of Visit: 8:00 a.m. to 5:30 p.m. 8:30 a.m. to 4:30 p.m.	Date Concluded: September 7, 2017				
Brooklyn Center			Investigator's Name and Title:				
State:	ZIP:	County:	 Carrie Euerle, R.N., Special Investigator Darlene Schwan, R.N., Special Investigator 				
Minnesota	55429	Hennepin					

🛛 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.

- **x** Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- **x** 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

Facility Name: Maranatha Care Center

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	a Vulnerable Adults Act (Minn	nesota Statutes, section 626.557):							
☐ Abuse	🛛 Neglect	Financial Exploitation							
Substantiated	□ Not Substantiated	☐ Inconclusive based on the following information:							
Mitigating Factors:	ors" in Minnesota Statutes, sec	tion 626.557, subdivision 9c (c) were considered and it was							
	\Box Individual(s) and/or \boxtimes Factors								
		ploitation. This determination was based on the following:							
administration error double checked by f	rs, the transcription and medic acility staff, however entered	in place to prevent medication transcription and cation error still occurred. The medication order was incorrectly. Over a six day period, five different staff Juestion of the dose or frequency of the medication.							
substantiated against	an identified employee, this re	to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services							

Facility Name: Maranatha Care Center

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:	x 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: X 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: X Yes INo

(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 Name: Maranatha Care Center

Report Number: H5462061

x Facility Po	olicies and Proced	lures			
Number of ad	lditional resident(s) reviewed: Two			
Specify:		on the allegation(s)	-) No () N/A	
Were resident	t(s) identified in tl	ne allegation(s) pres	ent in the facili	ty at the time of the	investigation?
○ Yes ● Specify: Disch	No 🔿 N/A narged				
Interviews: T	he following inte	rviews were condu	cted during th	e investigation:	
Interview with Specify:	9	⊖ Yes ⊖ No	● N/A	9	
If unable to co	ontact reporter, a	tempts were made	on:		
Date:	Time:	Date:	Time:	Date:	Time:
 Yes Did you interv Total number 	iew the resident(No ON/A S iew additional re of resident interv n staff: OYes	sidents? • Yes	No		
Total number Physician Inte Nurse Practitie Physician Assi	arning given as re of staff interview rviewed: ○Yes	s: <u>Seven</u> No Yes No Yes No 		A Specify:	
Attempts to c					
Date:	Time:	Date:	Time:	Date:	Time:
Were contact	s made with any o	ena issued: OYes, of the following: Police Officers D	·		O No

Facility Name: Maranatha Care Center

Observations were conducted related to:
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

		AND HUMAN SERVICES				FORM	: 10/17/2017 APPROVED : 0938-0391
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245462	B. WING	I			R-C
NAME OF I	PROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10	/05/2017
MARANA	ATHA CARE CENTER			54	409 69TH AVENUE NORTH		
				В	ROOKLYN CENTER, MN 55429		
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	completed, to follow related to complaint Care Center is in co 483, subpart B, requ Facilities. The facility is enrolle signature is not requ page of the CMS-25 correction is require	Revisit (PCR) was y up on deficiencies issued t #H5462061. Maranatha ompliance with 42 CFR Part uirements for Long Term Care ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.					
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		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.



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)

An equal opportunity employer.

Maranatha Care Center November 1, 2017 Page 2

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,

Kumala Riske 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: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

PRINTED: 10/17/2017 FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
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	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defici- herein are not corrected shall to with a schedule of fi- the Minnesota Depara Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of to lack of compliance. re-inspection with ar result in the assession	ether a violation has been				
	that may result from orders provided that the Department with	nearing on any assessments non-compliance with these a written request is made to in 15 days of receipt of a nt for non-compliance.				
	follow up on correcti complaint #H546026	S: ow up was completed, to on orders issued related to 31. Maranatha Care Center ance with state regulations.				
	The facility is enrolle	d in ePOC and therefore a				

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innesota Do	partment of Health					
ninosola De						

551412



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,

Kumala Riske 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

		AND HUMAN SERVICES				FORM	09/07/2017 APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIP	LE CONSTRUCTION		. 0938-0391
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MARANA	THA CARE CENTER				5409 69TH AVENUE NORTH		
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F 225 SS=D	to investigate case following deficiencie enrolled in ePOC at required at the botto CMS-2567 form. E POC will be used at	ndard survey was conducted #H5462061. As a result, the es are issued. The facility is nd therefore a signature is not om of the first page of the lectronic submission of the s verification of compliance. I)-(4) INVESTIGATE/REPORT DIVIDUALS	F 2	225			
	483.12(a) The facili	ty must-					
	(3) Not employ or o who-	therwise engage individuals					
		l guilty of abuse, neglect, propriation of property, or court of law;					
	nurse aide registry	ng entered into the State concerning abuse, neglect, atment of residents or their property; or					
	or her professional body as a result of a	ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.					
	licensing authorities actions by a court o	ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a facility staff.					
		llegations of abuse, neglect,					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

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F 225	exploitation, or mist (1) Ensure that all a abuse, neglect, exp including injuries of misappropriation of reported immediate after the allegation cause the allegation serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective serv for jurisdiction in lor accordance with Sta procedures. (2) Have evidence t thoroughly investigat (3) Prevent further p exploitation, or mist investigation is in pr (4) Report the result administrator or his representative and to with State law, inclu Agency, within 5 wo if the alleged violatio corrective action mu This REQUIREMEN by: Based on interview facility failed to repo State Agency (SA) r	reatment, the facility must: Illeged violations involving Ioitation or mistreatment, unknown source and resident property, are Iy, but not later than 2 hours is made, if the events that n involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other the facilities) in ate law through established that all alleged violations are the other designated to other officials in accordance ding to the State Survey whing days of the incident, and on is verified appropriate ust be taken. IT is not met as evidenced and document review the ort allegations of neglect to the	F2	225	5		

Event ID: 551411

Facility ID: 00226

If continuation sheet Page 2 of 19

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		APPROVED
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1			(X3) DATE SURVEY COMPLETED		
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F 225	R1 was admitted to which included infer prosthesis, streptor R1 admitted with pf 2017 for intervenou to an infection. After antibiotics, R1's phy physician changed to Levaquin 750 mg by mouth for 6 mon Physician's orders of antibiotic order was one tablet every oth knee infection due to ordered antibiotic. R1's May 2017 Med (MAR) indicated R1 transcribed as Leva other day however of per day. R1's May recieved the Levaque every other day for doses over a six da On 5/31/17 R1's Nur reviewed R1's medi R1's Levaquin 750 ma administered incorre	ation errors. d was reviewed and included the facility with diagnoses ction of the left knee coccal sepsis and pneumonia. hysician's orders dated March s (IV) and oral antibiotics due er completion of these vsician's orders indicated the her antibiotic order on 4/26/17 g every day, one time per day	F2	225			
		days instead of the ordered ne time per day every other					

Facility ID: 00226

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/07/2017 APPROVED 0938-0391
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F 225	day. The NP consul physician. The NP had R1 sent to the evaluation. The NP discovered transcrip Hospital records da treated for an over unintentional and in antiemetic medicati hospital. R1 returne evening with physic Levaquin for 48 hou R1's progress note indicated a call was check the status of indicated R1 would later that night and R1's system at the include to hold the L A progress noted da indicated R1 retured midnight. A facility Medication indicated a transcrip 5/26/17 and was no Levaquin 750 mg pl entered on R1's MA other day six times entered by the Heal and double checked however the error w medication was adr	Ited with the pharmacist and then called poison control and emergency room for an informed the facility of the ption error. ted 5/31/17 indicated R1 was lose of antibiotic, accidental or travenous (IV) fluids and an on was administered at the ed to the facility the same ian orders to hold the urs. dated 5/31/17 at 9:13 p.m. placed to the hospital to R1. The hospital nurse discharge back to the facility Levaquin was flushed out of hospital and new orders would Levaquin for 48 hours. ated 6/1/17 at 1:27 a.m. d from the hospital before a Variance Report dated 6/8/17 otion error occurred between the don 6/1/17 regarding R1's hysician's order which was VR as Levaquin 750 mg every per day. The order was th Unit Coordinator (HUC) d by a nurse, per facility policy, vas not caught and the ministered incorrectly over a The report included that the	F	225			

Facility ID: 00226

If continuation sheet Page 4 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
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F 225	On 7/27/2017, R1's and indicated Levad six times per day or 5/30/17 to R1 for a administered by five Interview with the D 7/27/17 at 1:45 p.m medication was tran administered incorr was not reported to she identified the m when informed by th signed R1's Medica and indicated the en because the medica had to be treated at overdose. Accordin should have been r R2 Reveiw of R2's medication admitted to the faci- included Alzheimer ⁴ condition where the are scarred and dat physician's orders of identified R2 had ph medication for Doxy antibiotic) 100 million per day by mouth for third month for lung 2016 physician ord was due in January November 2016 ph profilactic antibiotic Sulfamethoxazone/ 800/160 mg one tal	May 2017 MAR was reviewed quin 750 mg was administered in 5/26/17, 5/28/17, and total of 18 doses and e different staff members. Prirector of Nursing (DON) on . confirmed the R1's inscribed incorrectly and ectly by staff and the error the SA. The DON confirmed redication error on 6/1/17 the NP of the error. The DON tion Variance report 6/8/17 rror as a significant error due ation was an antibiotic and R1 the hospital for an antibiotic ing to facility policy, the error eported. dical record identified R1 was lity with diagnoses which is disease, bronchiectasis (a bronchial tubes of the lungs maged), and dementia. R2's dated November 2016 hysician orders for profilactic ycycline Hydrochloride (an grams (mg) one capsule twice or the first 10 days of every infection. The November lers indicated the medication 2017. R2 had further hysician's orders for another	F 2	225	5		

Facility ID: 00226

If continuation sheet Page 5 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	The physician order the antibiotic was d R2's January 2017 indicated R2 recieve prescribed. R2's MAR for March indicated R2 did no days of Doxycycline 2017 or the prescrit Sulfamethoxazone/	rs indicated the next round of ue in February 2017. and February 2017 MAR ed the medication as h 2017 and April 2017 t recieve the prescribed 10 e Hydrochloride for March	F 2	225			
	indicated R2 did no Doxycycline Hydrod prescribed Sulfame April 2017. The rep the antibiotic correc leading to the missi The report indicated medication error. R2's March 2017 ar	nce Report dated 5/4/17 t recieve the prescribed chloride for March 2017 or the athoxazone/Trimethoprim for ort indicated staff did not input atly in the specific months ng doses for March and April. d this was a significant and April 2017 progress notes t have noted side effects from					
	missing the March a antibiotic doses. R2 indicated R2 passe stage Alzheimer's D Interview with the D confirmed she had when reviewing mo infection control log identified R2's med it may have caused she did not report th	and April 2017 prescribed ?'s May 2017 progress notes d away on 5/27/2017 from end					

Facility ID: 00226

If continuation sheet Page 6 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245462	B. WING _		C 08/16/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MARANA	THA CARE CENTER			5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
SS=D	Policy dated April 20 of medical neglect " problems, prescribe under potential indic excess drugging, la misuse" of medicati indicated all allegati vulnerable 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre- exploitation of resider resident property, (2) Establish policie investigate any such (3) Include training a §483.95 (c) Abuse, neglect, a the freedom from all requirements in § 44	Adult Abuse Prevention Plan D17 identified under examples not taking action on medical ed treatment or therapies" and cators of neglect "signs of ck of medication, or othe on. The policy further ons of maltreatment against a 3.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC c develop and implement procedures that: vent abuse, neglect, and ents and misappropriation of s and procedures to	F 22	25		
-		constitute abuse, neglect, sappropriation of resident				

Facility ID: 00226

If continuation sheet Page 7 of 19

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245462	B. WING				C 16/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MARANA	THA CARE CENTER				5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	 property as set forth (c) (2) Procedures for neglect, exploitation resident property (c) (3) Dementia maprevention. This REQUIREMENDS by: Based on interview facility failed to implate a set of the set of the	-	F 2	226			
	admitted to the faci included infection o streptococcal sepsi admitted with physi 2017 for intervenou to an infection. Afte antibiotics, R1's physical	lity with diagnoses which f the left knee prosthesis, s and pneumonia. R1 cian's orders dated March s (IV) and oral antibiotics due					

Facility ID: 00226

If continuation sheet Page 8 of 19

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/07/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245462	B. WING				; 16/2017
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH		
MARANA	ATHA CARE CENTER			E	BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	to Levaquin 750 mg by mouth for 6 mon On 5/24/17, R1's p that R1's antibiotic of Levaquin 750 mg o six months for left k effects of previously R1's May 2017 Med (MAR) indicated R1 transcribed as Leva other day however per day. R1's May recieved the Levaq every other day for doses over a six da A facility Medication indicated a transcrip 5/26/17 and was no Levaquin 750 mg p entered on R1's MA other day six times entered by the Hea and double checker however the error w medication was adr period of six days. medication error wa On 7/27/2017, R1's and indicated Levag six times per day of 5/30/17 to R1 for a administered by five	g every day, one time per day ths. hysician's orders indicated order was changed to ne tablet every other day for mee infection due to side y ordered antibiotic. dication Administration Record 's Levaquin 750 mg was quin 750 mg one tablet every was scheduled for six times 2017 MAR indicated R1 uin 750mg six times per day three days for a total of 18 y period from 5/26/17-5/31/17. Nariance Report dated 6/8/17 otion error occurred between oted on 6/1/17 regarding R1's hysician's order which was AR as Levaquin 750 mg every per day. The order was Ith Unit Coordinator (HUC) d by a nurse, per facility policy, was not caught and the ministered incorrectly over a The report included that the	F 2	226			

Facility ID: 00226

If continuation sheet Page 9 of 19

CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0331 MATEMENT FOR PROVENES MY PROVENENUPULEIR-LIDENTIFICATION NUMBER 021 MULTIPLE CONSTRUCTION AND OF CORRECTION 245462 B WING CC MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, ZP CODE 021 MULTIPLE CONSTRUCTION MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, ZP CODE C MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF US DEMTIPHING INFORMATION PREMA TGO C Prema REGULATION OF US DEMTIPHING INFORMATION PREMA ROOKLOW CENTER, IM SEA29 CONSTRUCTION ADDRESS, CITY, STATE, ZP CODE C Prema REGULATION OF US DEMTIPHING INFORMATION PREMA ROOKLOW CENTER, IM SEA29 CONSTRUCTION ADDRESS, CITY, STATE, ZP CODE C Prema Receive of Profile Control of ADITS PREMA ROOKLOW CENTER, IM SEA29 C F 226 Continued From p			AND HUMAN SERVICES				FORM	APPROVED
C C 08/103 B WING C MARANATHA CARE CENTER STREETADDRESS, CITY, STATE, ZIP CODE Sege 67H AVENUE NORTH STREETADDRESS, CITY, STATE, ZIP CODE Sege 67H AVENUE NORTH STREETADDRESS, CITY, STATE, ZIP CODE MARANATHA CARE CENTER STREETADDRESS, CITY, STATE, ZIP CODE Image: Comparison of the comparison comparison of the comparison comparis dated comparison t	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION	(X3) DATE	E SURVEY
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, 2IP CODE MARANATHA CARE CENTER STREET ADDRESS, GTY, STATE, 2IP CODE Sequence Sequence PARIN Street ADDRESS, GTY, STATE, 2IP CODE Sequence Street Address Particity Street ADDRESS, GTY, STATE, 2IP CODE Sequence Street Address Particity Street ADDRESS, GTY, STATE, 2IP CODE Particity Street ADDRESS, GTY, STATE, 2IP CODE Particity Street ADDRESS, GTY, STATE, 2IP CODE Street ADDRESS, GTY, STATE, 2IP CODE Sequence Particity Street ADDRESS, GTY, STATE, 2IP CODE Particity Street ADDRESS, GTY, STATE, 2IP CODE Street ADDRESS, GTY, STATE, 2IP CODE Sequence Street ADDRESS, STY, STATE, 2IP CODE Sequence Street ADDRESS, STATE, 2IP CODE Sequence Street ADDRESS, STATE, 2IP CODE Sequence Street ADDRESS, STATE, 2IP CODE Sequence	AND I LAN O	I CONTRECTION	IDENTITION TOTAL TOTAL ON IDEN.	A. BUILDI	NG			
MARANATHA CARE CENTER See 85TH AVENUE NORTH BROOKLINA CENTER, NN 55429 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL (EACH CORRECTION SHOULD BE REAULTORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PREVENT CARTER APROPRIATE (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTION (EACH CORRECTION Signed R1'S MEDICA TO THE ORT OF TO SIGNED AT A AND AND AND AND AND AND AND AND AND A			245462	B. WING			08/	16/2017
MARANATHA CARE CENTER BROOKLYN CENTER, MN 55429 (X4) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRÉCEDUD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRÉVICERS 2014 CORRECTIVA STOTION HOUSE DE PRÉCEDUD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRÉVICERS 2014 (EACH DEFICIENCY) PRÉVICERS 2014 (EACH DEFICIENCY) COMPLETA (EACH DEFICIENCY) 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 signed R1's Medication Variance report and indicated the error as a significant error due to the medication on 6/1/17 and indicated this was because the medication was an antibiotic and R1 had to be treated at the hospital for an antibiotic overdese and according to facility policy, the error should have been reported. F2 F2 Review of R2's medical record identified R1 was admitted to the facility with diagnoses which included Azheimer's disease, bronchicatasis (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 (antified R2 had physician orders for profilactic medication for Doxycycline Hydrochoride (an antibiotic) 100 miligrams (mg) one capsule twice per day by mouth for the first 10 days of every third month for lung infection. The November 2016 physician's orders for another profilactic antibiotic) for Suffamethoxazone/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.	NAME OF PROVIDER OR SUPPLIER							
Pričejki TAG IEACH ORENCIENCY MUST BE PRECEDB DY FULL REQUINTRY OR ISC IDENTRYING INFORMATION) PRĚTX TAG IEACH CORRETIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPOPRIATE DEFICIENCY) Conviction on DATE 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 whein 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 go in antibiotic overdose and according to facility policy, the error should have been reported. F 226 R2 Reveiw of R2's medical record identified R1 was admitted to the facility with diagnoses which included Atzheimer's disease, bronchiectasis (a condition where the bronchia tubes of the lungs are scared and damaged), and dementia. Review of R2's physician's orders dated November 2016 identified R2 had physician orders for profilactic medication for Doxycycline Hydrochord(e anthibiotic) 100 milligrants (mg) one capsule twice per day by mouth for the first 10 days of every third month for lung infection. The November 2016 physician's orders indicated the medication was due in January 2017. R2 had further November 2016 physician's orders indicated the antibiotic for Sulfamethoxazone/Trimethoppin (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.	MARANA	THA CARE CENTER						
 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, bronchicetasis (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's orders for another profilactic antibiotic for Sulfamethoxazone/Trimethoprim (an antibiotic) 800/160 mg ere the indect for first 10 days of every third month for lung infection. The physician orders indicated the needication tor for solid 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. 	PREFIX	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
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'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.	F 226	medication was tran administered incorr was not reported to she identified the m when informed by th signed R1's Medica indicated the error a medication on 6/8/1 because the medica had to be treated at overdose and accor should have been re	nscribed incorrectly and ectly by staff and the error the SA. The DON confirmed edication error on 6/1/17 he NP of the error. The DON tion Variance report and as a significant error due to the 7 and indicated this was ation was an antibiotic and R1 the hospital for an antibiotic rding to facility policy, the error	F 2	26			
MAR confirmed R2 recieved the medication as		admitted to the facili included Alzheimer's condition where the are scarred and dar Review of R2's phys November 2016 ide orders for profilaction Hydrochloride (an a one capsule twice p 10 days of every thi The November 2011 the medication was further November 2011 the physician order the antibiotic was due	lity with diagnoses which s disease, bronchiectasis (a bronchial tubes of the lungs maged), and dementia. sician's orders dated entified R2 had physician c medication for Doxycycline intibiotic) 100 milligrams (mg) ber day by mouth for the first rd month for lung infection. 6 physician orders indicated due in January 2017. R2 had 016 physician's orders for intibiotic for Trimethoprim (an antibiotic) to one time per day for the first rd month for lung infection. rs indicated the next round of ue in February 2017. uary 2017 and February 2017					

Facility ID: 00226

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		AND HUMAN SERVICES			F	ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		B) DATE SURVEY COMPLETED
		245462	B. WING			C 08/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
MARANA	THA CARE CENTER			5409 69TH AVENUE NORTH BROOKLYN CENTER, MN	55429	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 226	reviewed and indica prescribed 10 days for March 2017 or t Sulfamethoxazone/	ige 10 h 2017 and April 2017 were ated R2 did not recieve the of Doxycycline Hydrochloride he prescribed 10 days of the Trimethoprim for April 2017, sed doses of antibiotics.	F 2	26		
	indicated R2 did no Doxycycline Hydrod prescribed Sulfame April 2017. The rep the antibiotic correct leading to the missi	t recieve the prescribed chloride for March 2017 or the ethoxazone/Trimethoprim for ort indicated staff did not input ctly in the specific months ing doses for March 2017 and port indicated this was a on error.				
	indicated R2 did no missing the March antibiotic doses. Fu progress notes indi	nd April 2017 progress notes t have noted side effects from and April 2017 prescribed inther review of R2's May 2017 cated R2 passed away on d stage Alzheimer's Disease.				
F 333 SS=G	confirmed she had when reviewing mo infection control log identified R2's med it may have caused she did not report to		F 3	33		
00=0	483.45(f) Medicatio					
FORM CMS-25	i67(02-99) Previous Versions	Obsolete Event ID: 55l411		Facility ID: 00226	If continuation	sheet Page 11 of 19

		AND HUMAN SERVICES				FORM	09/07/2017 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		245462	B. WING	i			C 16/2017
NAME OF PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
MARANA	THA CARE CENTER				5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	Continued From pa	ge 11	F	333	8		
	The facility must en	sure that its-					
	medication errors. This REQUIREMEN by: Based on interview facility failed to ensu- reviewed were free errors when R1's ar- administered incorr- needed treatment a overdose. Addition- were transcribed incorr- months of the preso Findings include: R1's medical record the facility with diag infection of the left A sepsis and pneumo and admitted with p intervenous (IV) and infection. After corr R1's physician char 4/26/17 to Levaquin per day by mouth for Review of R1's phys 5/24/17 that R1's ar Levaquin 750 mg on six months for left k	I included R1 was admitted to noses which included (nee prosthesis, streptococcal nia. R1 was cognitively intact hysician's orders for d oral antibiotics due to an apletion of these antibiotics, aged her antibiotic order on 750 mg every day, one time or 6 months. sician's orders indicated on ntibiotic order was changed to ne tablet every other day for nee infection due to side ordered antibiotic.					
	(MAR) indicated R1	lication Administration Record 's Levaquin 750 mg was quin 750 mg one tablet every	_				

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 survey
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		245462	B. WING		· · · · ·		C 16/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2017
MARANA	THA CARE CENTER						
				8	BROOKLYN CENTER, MN 55429		() (2)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	other day however per day. R1's May recieved the Levag every other day for doses over a six da Review of R1's prog 12:04 p.m. indicates shaking on her upp mentioned to staff s "stroke". Facility sta signs, which were v shaking was observ had equal hand gra was alert and had n R1's blood sugar was on-call nurse practif directed staff to cor condition. A progress note dat indicated R1 had ar p.m. R1 indicated to emesis and staff no monitor R1. A progress note dat indicated R1 had a and R1's blood pres vital signs were with requested to speak following morning. A progress note dat indicated R1 was "r "observed to be any	was scheduled for six times 2017 MAR indicated R1 uin 750mg six times per day three days for a total of 18 by period from 5/26/17-5/31/17. gress note dated 5/29/17 at d R1 "verbalied she had er extremities last night" and she thought she was having a tiff documented R1's vital within normal limits. No ved by staff. Staff observed R1 sps, no shortness of breath, no changes in mentation and as within normal limits. An tioner was updated who nationer was updated who nationer was updated who nationer was updated who attribute to monitor R1's the 5/29/17 at 10:15 p.m. in emesis after dinner at 5:00 to staff she felt better after the oted they would continue to the form of the system of the evening soure was low, however other nin normal range. R1 with the nurse practitioner the the 5/31/17 at 5:51 a.m. needy with cares" and kious" and staff indicated they	F3	33			
	indicated R1 was "r	needy with cares" and kious" and staff indicated they					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/07/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245462	B. WING _		C 08/16/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH		
MARANATHA CARE CENTER			BROOKLYN CENTER, MN 55429			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Continued From pa	ge 13	F 33	33	•	
	R1's medical record Levaquin 750mg wa administered incorr from 5/26/17-5/31/1 recieved the medica other day for three of Levaquin 750 mg of day. The NP consul physician. The NP had R1 sent to the of evaluation. R1's progress note indicated a call was check the status of indicated R1 would later that night and R1's system at the l include to hold the L Hospital records da treated for an overd unintentional and in administered at the facility the same even to hold the Levaquin A progress noted da indicated R1 returner midnight. A facility Medication indicated a transcrip 5/26/17 and was no Levaquin750 mg ph	ectly over the last six days 7. R1's MAR indicated R1 ation six times per day every days instead of the order of ne time per day every other ted with the pharmacist and then called poison control and emergency room for an dated 5/31/17 at 9:13 p.m. placed to the hospital to R1. The hospital nurse discharge back to the facility Levaquin was flushed out of hospital and new orders would Levaquin for 48 hours. ted 5/31/17 indicated R1 was lose of antibiotic, accidental or travenous (IV) fluids were hospital. R1 returned to the ening with physician's orders				

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			F		: 09/07/2017 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	.				. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY
		245462	B. WING				C / 16/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2011
MARAN	ATHA CARE CENTER			5	409 69TH AVENUE NORTH		
				B	BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 333	entered by the Heal and double checked however the error w medication was adr period of six days. medication error wa On 7/27/2017, R1's and indicated Levad six times per day or 5/30/17 to R1 for a t administered by 5 d Interview with the H (HUC)-A on 7/27/17 had entered R1's pf 750 mg and did not box that indicated th six times per day. H read the order wron should have also be check of the medica order being changed record. Interview the Regist 7/27/17 at 12:20 p.m manager on R1's ur was indicated on R1 he had second check computer prior to the the MAR and in R1's RN-B stated he had signed off in the com off as double checked then signed off on th RN-B admitted he d frequency of the tim medication under th	th Unit Coordinator (HUC) d by a nurse, per facility policy, /as not caught and the ninistered incorrectly over a The report included that the	F 3	33			

Facility ID: 00226

		AND HUMAN SERVICES				FOR	D: 09/07/2017
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		245462	B. WING			08	C 8/ 16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP COD	E	/10/2011
MARANATHA CARE CENTER			5409 69TH AVE	NUE NORTH			
				BROOKLYN	CENTER, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	DVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
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Facility ID: 00226

If continuation sheet Page 16 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245462 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/16/2017 MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				FORM	09/07/2017 APPROVED	
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Event ID: 551411

Facility ID: 00226

If continuation sheet Page 17 of 19

		AND HUMAN SERVICES				FORM): 09/07/2017 /I APPROVED
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	infection control log. discussed the error error and held an all physician orders and DON further confirm enter orders correct order was difficult to herself about the ord	The DON further stated she with the staff who entered the staff meeting on input of d transcription of orders. The hed she expected staff to ly per facility policy and if the ask another staff member or der prior to entering it in the					
	Administration Error indicated medication	ded entitled Medication Policy dated August 2015 ns not prepared or ordance with prescribers					

Facility ID: 00226

If continuation sheet Page 18 of 19

		AND HUMAN SERVICES				FORM	09/07/2017	
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Facility ID: 00226

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: 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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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.

Maranatha Care Center September 14, 2017 Page 2 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; <u>OR</u>
- 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; <u>OR</u>
- 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) <u>AND</u> 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:

Maranatha Care Center September 14, 2017 Page 3

• 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.

Maranatha Care Center September 14, 2017 Page 4 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: Maranatha Care Center September 14, 2017 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala 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: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File
Minneso	ta Department of He	alth				
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	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defice herein are not correct not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	nearing on any assessments non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
<i>l</i> innesota De	investigate complain following correction has agreed to partic of State licensure on	ation was conducted to nt #H5432061. As a result, the orders are issued. The facility ipate in the electronic receipt rders consistent with the ent of Health Informational				

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

TITLE

(X6) DATE

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	obul.htm The State delineated on the a Department of Hea electronically. Altho necessary for State the word "corrected Then indicate in the process, under the date your orders wi	Ith orders being submitted ugh no plan of correction is Statutes/Rules, please enter " in the box available for text. e electronic State licensure heading completion date, the Il be corrected prior to itting to the Minnesota				
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			
	percent as describe Guidelines for Code 42, section 483.25 the State Operation Surveyors for Long- incorporated by refe purposes of this par (1) a discrepar prescribed and wha administered to res (2) the administ medications.	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was it medications are actually idents in the nursing home; or stration of expired				
	error. A significant (1) an error v discomfort or jeopa safety; or (2) medication requires the medication	which causes the resident rdizes the resident's health or on from a category that usually ation in the resident's blood to				
	medication error co	ific blood level and a single uld alter that level and irrence of symptoms or				

Minnesota Department of Health STATE FORM

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551411

If continuation sheet 2 of 24

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NUMBER:				E SURVEY PLETED
		00226	B. WING			C 16/2017
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		5409 691	H AVENUE N	ORTH		
	ATHA CARE CENTER	BROOKL	YN CENTER,	MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21545	Continued From pa	ige 2	21545		Par Josh	
	toxicity. All medicat	ions are administered as				
	prescribed. An inc	ident report or medication				
	error report must b	e filed for any medication error				
	resident reactions	gnificant medication errors or nust be reported to the				
ph re		vsician's designee and the				
	resident or the resident	dent's legal guardian or				
	designated represe	ntative and an explanation				
		e resident's clinical record.				
		ons are administered as dent report or medication error				
		for any medication error that				
	occurs. Any signific	cant medication errors or	1			
		nust be reported to the				
		/sician's designee and the lent's legal guardian or				
		ntative and an explanation				
	must be made in th	e resident's clinical record.				
1	by:	ent is not met as evidenced				
		and document review the				
	facility failed to ensu	ure 2 of 3 residents (R1, R2)				
		of significant medication				
		ntibiotic was transcribed and				
		ectly. Harm occurred when ne hospital for an antibiotic				
		ally, R2's antibiotic orders				
	were transcribed in	correctly and R2 missed two				
	months of the prese	ribed antibiotic.				
	Findings include:					
	R1's medical record	I included R1 was admitted to				
	the facility with diag	noses which included				
	infection of the left l	nee prosthesis, streptococcal				
	sepsis and pneumo	nia. R1 was cognitively intact				
	and admitted with p	hysician's orders for				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226		CONSTRUCTION	СОМ	E SURVEY PLETED C 16/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
MARAN	ATHA CARE CENTER		'H AVENUE NO YN CENTER, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21545	Continued From pa	ge 3	21545		0419 <u>44</u>		
	 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 one tablet every other day however was scheduled for six times per day. R1's May 2017 MAR indicated R1 recieved the Levaquin 750 mg six times per day every other day for three days for a total of 18 						
	Review of R1's prog 12:04 p.m. indicated shaking on her upper mentioned to staff s "stroke". Facility sta signs, which were w shaking was observe had equal hand grass was alert and had n R1's blood sugar was on-call nurse practit directed staff to con condition. A progress note dat indicated R1 had ar p.m. R1 indicated to	y period from 5/26/17-5/31/17. gress note dated 5/29/17 at d R1 "verbalied she had er extremities last night" and he thought she was having a ff documented R1's vital vithin normal limits. No red by staff. Staff observed R1 sps, no shortness of breath, o changes in mentation and as within normal limits. An ioner was updated who tinue to monitor R1's ed 5/29/17 at 10:15 p.m. a emesis after dinner at 5:00 o staff she felt better after the ted they would continue to					

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If continuation sheet 4 of 24

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00000	B. WING		С	
	PROVIDER OR SUPPLIER	00226	DRESS, CITY, S		08/16/2017	
		5409 69T	H AVENUE NO	•		
MARANA	ATHA CARE CENTER		YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE
21545	Continued From pa	age 4	21545			
	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.					
	indicated R1 was "	ted 5/31/17 at 5:51 a.m. needy with cares" and xious" and staff indicated they nonitor R1.				
	at 1:41 p.m. confirm review of R1's med R1's Levaquin 750 administered incom from 5/26/17-5/31/ recieved the medic other day for three Levaquin 750 mg c day. The NP consu physician. The NP	ne Nurse Practitioner on 8/4/17 med that on 5/31/17 during lical record, she discovered mg was transcribed and rectly over the last six days 17. R1's MAR indicated R1 ration six times per day every days instead of the order of one time per day every other lited with the pharmacist and then called poison control and emergency room for an				
	treated for an over unintentional and ir administered at the	ated 5/31/17 indicated R1 was dose of antibiotic, accidental or ntravenous (IV) fluids were hospital. R1 returned to the rening with physician's orders n for 48 hours.				
	indicated a call was check the status of	dated 5/31/17 at 9:13 p.m. s placed to the hospital to R1. The hospital nurse discharge back to the facility				

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If continuation sheet 5 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00226	B. WING			C 08/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
IARANA	ATHA CARE CENTER		H AVENUE NO YN CENTER, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21545	Continued From pa	age 5	21545	and the second	19-11-28-81		
	R1's system at the include to hold the A progress noted d	Levaquin was flushed out of hospital and new orders would Levaquin for 48 hours. lated 6/1/17 at 1:27 a.m. hed from the hospital before					
	indicated a transcri 5/26/17 and was no Levaquin750 mg pl entered on R1's M/ other day six times entered by the Hea and double checke however the error v medication was ad period of six days. medication error was	-					
	and indicated Leva six times per day o 5/30/17 to R1 for a administered by 5 o Interview with the H (HUC)-A on 7/27/17 had entered R1's p 750 mg and did not box that indicated t six times per day. H read the order wron should have also be check of the medic order being change record.	s May 2017 MAR was reviewed quin 750 mg was administered n 5/26/17, 5/28/17, and total of 18 doses and different staff members. Health Unit Coordinator 7 at 10:40 a.m. indicated she hysician order for Levoquin t realize she had checked the he medication was to be given HUC-A stated she "must have ng". HUC-A indicated this error een caught on the second ation by the nurse prior to the ed on R1's MAR and medical					
		tered Nurse (RN)-B on m. indicated he was the nurse					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		C		
		00226	B. WING	B. WING		08/16/2017	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IARAN/	THA CARE CENTER		TH AVENUE NO YN CENTER, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
	was indicated on F he had second che computer prior to t the MAR and in R1 RN-B stated he ha signed off in the co off as double chec then signed off on RN-B admitted he frequency of the tir medication under t MAR. RN-B stated entire order before	Init. RN-B confirmed his name At's electronic orders indicated ecked the orders in the he orders being changed on 's electronic medical record. d observed the orders were no omputer, however were signed ked in R1's paper chart and he the orders in the computer. did not check to see the ne of administration of the he physician's order on the d he should have checked the signing off on the order.	t				
	7/27/17 at 1:45 p.m medication was tra administered incor confirmed she ider significant error du antibiotic and R1 h hospital for an antii stated the HUC an Levoquin order had retrained. The DOI worked at the facili was discovered. The the medication error 6/8/17 and not on 8 error was discover she expected all st orders to follow factor	h. confirmed the R1's inscribed incorrectly and rectly by staff. The DON tifed the medication error as a e to the medication being an aving to be treated at the biotic overdose. The DON d RN-B who transcribed R1's d been re-educated and N stated LPN-A no longer ty when the medication error the DON could not indicate why or report was filled out on 5/31/17 when the medication ed. The DON futher stated aff who enter physician's sility policy and check the order e signing off on physician					
	confirmed she reca stated "it was awfu	n 8/2/17 at 11:02 a.m. alled the medication error. R1 I" and now "questions every given to her". R1 could not					

STATEMEN	ta Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00226	B. WING			C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MARANA	ATHA CARE CENTER		I AVENUE NO 'N CENTER, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21545	Continued From pa	age 7	21545			
	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.					
	(LPN)-A on 8/3/17 off on the second c orders for Levoquin she was not aware	icensed practical nurse at 11:14 a.m. who had signed check of R1's paper physician n 750 mg on 5/26/17, indicated of a medication error roquin as she no longer worked				
	8/4/17 at 1:41 p.m. medication error at complaints of shak movements. The f review of R1's pres discovered the error discussed the med pharmacist who dir and have R1 sent t for an evaluation. T the facility it was a felt that staff admin	Nurse Practitioner (NP) on confirmed she found the fter being informed of R1's ing and quivering mouth NP was doing a medication scribed medication when she or. The NP stated she lication error with the rected her to call poison control to the emergency room (ER) The NP stated she was told by transcription error, however histering the medication should be amount and frequency of the iven.				
	admitted to the fact included Alzheimer condition where the are scarred and da admitted to the fact Doxycycline Hydrod milligrams (mg) on mouth for the first	dical record included R2 was lity with diagnoses which 's disease, bronchiectasis (a e bronchial tubes of the lungs maged), and dementia. R2 lity with physician orders for chloride (an antibiotic) 100 e capsule twice per day by 10 days of every third month ment of lung infection. The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE A. BUILDING: B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/16/2017	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S		00/10/2011	
			HAVENUE NO			
MARANA	THA CARE CENTER		YN CENTER,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
	due in January. R2 for Sulfamethoxazo antibiotic) 800/160 m for the first 10 days profolactic treatmen physician orders ind antibiotic was due in R2's MAR for March indicated R2 did not Doxycycline Hydroc prescribed Sulfame April 2017, for a tota profalactic antibiotic A Medication Varian indicated R2 did not Doxycycline Hydroc prescribed Sulfame April 2017. The repor the antibiotic correc leading to the missin The report indicated medication error. R2's medical record noted side effects fr and April 2017 presc passed away on 5/2 Alzheimer's Disease Interview with the Di confirmed she had f when reviewing mor infection control log. discussed the error error and held an all	licated the medication was had further physician's orders ne/Trimethoprim (an mg one tab one time per day of every third month for it lung infection. The licated the next round of the n February. A 2017 and April 2017 trecieve the prescribed hloride for March 2017 or the thoxazone/Trimethoprim for al of 20 missed doses of s. ce Report dated 5/4/17 trecieve the prescribed hloride for March 2017 or the thoxazone/Trimethoprim for ort indicated staff did not input thy in the specific months ng doses for March and April. this was a significant indicated R2 did not have om missing the March 2017 cribed antibiotic doses. R2 7/2017 from end stage	21545			

Minnesc	ota Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00226	B. WING		1	C 1 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
MARAN	ATHA CARE CENTER			, MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 9	21545			
	enter orders correc order was difficult to	tly per facility policy and if the o ask another staff member or der prior to entering it in the				
	Administration Erro indicated medicatio administered in acc orders, manufacture accepted profession regulations is define policy further indica error means one wh discomfort or jeapo safety. The policy in determining signific	ordance with prescribers er's specifications, or nal standard and practice ed as a medication error. The ted a significant medication nich causes the resident rdizes his/her health and ncluded criteria for ance of medication error ondition, drug category and				
	The facility administ (DON) or designee and procedures, ed ongoing monitoring	HOD OF CORRECTION: trator and director of nursing could review facility policies ucate staff and implement an system to ensure all resident transcribed and implemented ician orders.				
	TIME PERIOD TO (days	CORRECT: Twenty-one (21)				
21850	MN St. Statute 144. Residents of HC Fa	651 Subd. 14 Patients & c.Bill of Rights	21850			
		m from maltreatment.				
Ainnesota De	epartment of Health					

Minnesota Department STATE FORM

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If continuation sheet 10 of 24

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
	**************************************	00226	B. WING		08/16/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IARAN/	THA CARE CENTER		TH AVENUE NO LYN CENTER, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21850	Continued From pa	age 10	21850			
	defined in the Vuln "Maltreatment" me section 626.5572, intentional and nor physical pain or inj conduct intended t distress. Every res non-therapeutic ch except in fully docu authorized in writin resident's physician period of time, and	free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the n-therapeutic infliction of ury, or any persistent course of o produce mental or emotional sident shall also be free from nemical and physical restraints, umented emergencies, or as g after examination by a n for a specified and limited only when necessary to t from self-injury or injury to				
	by: Based on document facility failed to ensign reviewed was free when staff incorrect antibiotic. R1 requi	tent is not met as evidenced nt review and interviews the sure 1 of 3 residents (R1) from maltreatment when R1 stly administered a prescribed ired emergency room n antibiotic overdose.				
	Findings include:			`		
	the facility with diag infection of the left sepsis and pneume and admitted with p intervenous (IV) an infection. After cor	d included R1 was admitted to gnoses which included knee prosthesis, streptococcal onia. R1 was cognitively intact physician's orders for id oral antibiotics due to an inpletion of these antibiotics,				
	R1's physician cha	nged her antibiotic order on n 750 mg every day, one time				
		vsician's orders indicated on ntibiotic order was changed to				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00226	B. WING	B. WING		C 08/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
MARANA	THA CARE CENTER		TH AVENUE NO				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21850	Continued From pa	age 11	21850				
	six months for left I	one tablet every other day for knee infection due to side y ordered antibiotic.					
	(MAR) indicated R transcribed as Leva other day however per day. R1's May recieved the Levaq every other day for	dication Administration Record 1's Levaquin 750 mg was aquin 750 mg one tablet every was scheduled for six times 2017 MAR indicated R1 uin 750mg six times per day three days for a total of 18 ay period from 5/26/17-5/31/17					
	12:04 p.m. indicate shaking on her upp mentioned to staff "stroke". Facility sta signs, which were w shaking was obsern had equal hand gra was alert and had r R1's blood sugar w on-call nurse practi	gress note dated 5/29/17 at d R1 "verbalied she had her extremities last night" and she thought she was having a aff documented R1's vital within normal limits. No ved by staff. Staff observed R1 usps, no shortness of breath, no changes in mentation and as within normal limits. An tioner was updated who ntinue to monitor R1's					
	indicated R1 had an p.m. R1 indicated to	ted 5/29/17 at 10:15 p.m. n emesis after dinner at 5:00 o staff she felt better after the oted they would continue to					
	indicated R1's appedue to complaints of indicated R1 had a and R1's blood pre- vital signs were with	ted 5/30/17 at 9:25 p.m. etite and fluid intake was low of nausea. The note further small emesis in the evening ssure was low, however other hin normal range. R1 with the nurse practitioner the					

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00226	B. WING		08/1	C 6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
		5400 607	H AVENUE N			
WARANA	THA CARE CENTER	BROOKL	YN CENTER,	MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	Continued From pa	age 12	21850			
	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.					
		d and discovered R1's as transcribed and rectly over the last six days 17. R1's MAR indicated R1 ation six times per day every days instead of the order of ne time per day every other lted with the pharmacist and then called poison control and				
	indicated a call was check the status of indicated R1 would later that night and R1's system at the	dated 5/31/17 at 9:13 p.m. placed to the hospital to R1. The hospital nurse discharge back to the facility Levaquin was flushed out of hospital and new orders would Levaquin for 48 hours.		н —		
	treated for an overc unintentional and in administered at the	ted 5/31/17 indicated R1 was lose of antibiotic, accidental or travenous (IV) fluids were hospital. R1 returned to the ening with physician's orders n for 48 hours.				
		ated 6/1/17 at 1:27 a.m. ed from the hospital before				
		Variance Report dated 6/8/17				
innesota De TATE FORM	partment of Health		6899 p	551411	If continuation	sheet 13 of 24

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00226	B. WING		1	C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MARANA	ATHA CARE CENTER		H AVENUE NO YN CENTER,			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	OBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET
21850	Continued From pa	age 13	21850		- Ma	
	5/26/17 and was no Levaquin750 mg pl entered on R1's M/ other day six times entered by the Hea and double checke however the error v medication was add period of six days. medication error wa On 7/27/2017, R1's and indicated Leva six times per day of 5/30/17 to R1 for a administered by 5 c Interview with the H (HUC)-A on 7/27/17 had entered R1's p 750 mg and did not box that indicated t six times per day. H read the order wror should have also be check of the medicated to administered by 5 c	ption error occurred on bred on 6/1/17 regarding R1's hysician's order which was AR as Levaquin 750 mg every per day. The order was lth Unit Coordinator (HUC) d by a nurse, per facility policy, was not caught and the ministered incorrectly over a The report included that the as "significant". May 2017 MAR was reviewed quin 750 mg was administered n 5/26/17, 5/28/17, and total of 18 doses and different staff members. Health Unit Coordinator 7 at 10:40 a.m. indicated she hysician order for Levoquin t realize she had checked the he medication was to be given HUC-A stated she "must have ng". HUC-A indicated this error een caught on the second ation by the nurse prior to the ed on R1's MAR and medical				
	7/27/17 at 12:20 p.r manager on R1's u was indicated on R he had second che	tered Nurse (RN)-B on m. indicated he was the nurse nit. RN-B confirmed his name 1's electronic orders indicated cked the orders in the				
	the MAR and in R1 RN-B stated he had signed off in the con	ne orders being changed on 's electronic medical record. I observed the orders were not mputer, however were signed				
nonoto Dr		ed in R1's paper chart and he he orders in the computer.				

STATEMEN	ta Department of H TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00226	B. WING	B. WING		C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MARANA	ATHA CARE CENTER		TH AVENUE NO			
		BROOKI	YN CENTER,	MN 55429		·,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21850	Continued From pa	age 14	21850			
	frequency of the tir medication under t MAR. RN-B stated entire order before Interview with the I 7/27/17 at 1:45 p.m medication was tra administered incor confirmed she ider significant error du antibiotic and R1 h hospital for an antii stated the HUC an Levoquin order had retrained. The DON worked at the facili was discovered. Th the medication error 6/8/17 and not on 8 error was discovered she expected all st orders to follow factor	did not check to see the me of administration of the the physician's order on the d he should have checked the signing off on the order. Director of Nursing (DON) on n. confirmed the R1's unscribed incorrectly and rectly by staff. The DON ntifed the medication error as a e to the medication being an aving to be treated at the biotic overdose. The DON d RN-B who transcribed R1's d been re-educated and N stated LPN-A no longer ty when the medication error ne DON could not indicate why or report was filled out on 5/31/17 when the medication ed. The DON futher stated aff who enter physician's cility policy and check the order e signing off on physician				
	confirmed she reca stated "it was awfu medication that is g recall the details of she was "given too	on 8/2/17 at 11:02 a.m. alled the medication error. R1 I" and now "questions every given to her". R1 could not the medication error, but knew much" of the medication and he was treated in the hospital.	,			
	(LPN)-A on 8/3/17 a off on the second of orders for Levoquir	icensed practical nurse at 11:14 a.m. who had signed check of R1's paper physician 750 mg on 5/26/17, indicated of a medication error				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00226	B. WING		1	C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	ATHA CARE CENTER	5409 69TH	HAVENUE NO	DRTH		
		BROOKLY	YN CENTER,	MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21850	Continued From pa	age 15	21850			
	regarding R1's Lev at the facility.	oquin as she no longer worked				
	8/4/17 at 1:41 p.m. medication error af complaints of shak movements. The N review of R1's pres discovered the error discussed the med pharmacist who dir and have R1 sent t for an evaluation. T the facility it was a felt that staff admin	Nurse Practitioner (NP) on confirmed she found the fter being informed of R1's ing and quivering mouth NP was doing a medication scribed medication when she or. The NP stated she lication error with the rected her to call poison control to the emergency room (ER) The NP stated she was told by transcription error, however histering the medication should he amount and frequency of the jiven.				
	admitted to the fact included Alzheimer condition where the are scarred and da admitted to the fact November 2016 for (an antibiotic) 100 r twice per day by m every third month f infection. The Nov indicated the medic had further physicia 2016 for Sulfameth antibiotic) 800/160	dical record included R2 was ility with diagnoses which 's disease, bronchiectasis (a e bronchial tubes of the lungs imaged), and dementia. R2 ility with physician orders dated r Doxycycline Hydrochloride milligrams (mg) one capsule outh for the first 10 days of or profolactic treatment of lung rember 2016 physician orders cation was due in January. R2 an's orders dated November noxazone/Trimethoprim (an mg one tab one time per day s of every third month for				

STATEMEN	ta Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		DENTIFICATION NOMBER.	A. BUILDING: _			
		00226	B. WING		C 08/16/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MARANA	THA CARE CENTER		H AVENUE NO YN CENTER, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21850	Continued From pa	age 16	21850	990 U		
	indicated R2 did no Doxycycline Hydro prescribed Sulfame	ch 2017 and April 2017 ot recieve the prescribed chloride for March 2017 or the ethoxazone/Trimethoprim for tal of 20 missed doses of ics.				
	indicated R2 did no Doxycycline Hydro prescribed Sulfame April 2017. The rep the antibiotic corre leading to the miss	nce Report dated 5/4/17 ot recieve the prescribed chloride for March 2017 or the ethoxazone/Trimethoprim for port indicated staff did not input ctly in the specific months sing doses for March and April. of this was a significant				
	noted side effects t and April 2017 pres	d indicated R2 did not have from missing the March 2017 scribed antibiotic doses. R2 27/2017 from end stage se.				
	confirmed she had when reviewing mo infection control log discussed the erro error and held an a physician orders an DON further confir enter orders correct order was difficult t	DON on 7/27/17 at 1:45 p.m. found R2's medication errors onthly antibiotics for an g. The DON further stated she r with the staff who entered the all staff meeting on input of nd transcription of orders. The med she expected staff to otly per facility policy and if the to ask another staff member or rder prior to entering it in the				
	Administration Error indicated medication	vided entitled Medication or Policy dated August 2015 ons not prepared or				
TE FORM	epartment of Health 1		⁶⁸⁹⁹ 55	51411	If continuation	on sheet 17

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	of connection	IDENTIFICATION NOMBER.	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·		
		00226	B. WING			C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MARANA	ATHA CARE CENTER		H AVENUE NO YN CENTER, I			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21850	Continued From pa	age 17	21850			
	orders, manufactur accepted professio regulations is defin policy further indica error means one w discomfort or jeapo safety. The policy determining signific	cordance with prescribers rer's specifications, or onal standard and practice led as a medication error. The ated a significant medication which causes the resident ordizes his/her health and included criteria for cance of medication error condition, drug category and ror.				
	The administrator, educate involved st following the current transcribing medicat following physician designee could educe abuse/neglect prevent and audit staff compared orders. The DON of quality assurance of TIME PERIOD TO	rention policy and procedure opliance regarding staff ng facility policy and physician could report the findings to the				
21980	days MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			
	reporter who has revulnerable adult is or who has knowled has sustained a ph reasonably explained	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an				

Minnesota Department of Health STATE FORM

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(X3) DATE SURVEY COMPLETED	
C 08/1) 6/2017
RECTION	(YE)
HOULD BE PPROPRIATE	(X5) COMPLET DATE

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STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00226	B. WING		1	C 08/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
	ATHA CARE CENTER		H AVENUE NO				
		BROOKL	YN CENTER,			-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21980	Continued From pa	age 19	21980				
	the report under su	bdivision 9c.					
	by: Based on interview facility failed to repo State Agency (SA)r	ent is not met as evidenced and document review, the ort allegations of neglect to the elated to significant or 2 of 3 residents (R1, R2) ation errors.					
	Findings include:						
	R1 was admitted to which included infe prosthesis, streptor R1 admitted with pl 2017 for intervenou to an infection. Afte antibiotics, R1's phy physician changed	d was reviewed and included the facility with diagnoses ction of the left knee coccal sepsis and pneumonia. hysician's orders dated March is (IV) and oral antibiotics due er completion of these ysician's orders indicated the her antibiotic order on 4/26/17 g every day, one time per day iths.					
	antibiotic order was one tablet every oth	dated 5/24/17, indicated R1's changed to Levaquin 750 mg her day for six months for left to side effects of previously					
	(MAR) indicated R1 transcribed as Leva other day however per day. R1's May recieved the Levag every other day for	dication Administration Record 's Levaquin 750 mg was aquin 750 mg one tablet every was scheduled for six times 2017 MAR indicated R1 uin 750mg six times per day three days for a total of 18 by period from 5/26/17-5/31/17.					

	ta Department of He	ealth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00226	B. WING		C 08/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MARANA	THA CARE CENTER	5409 69T	H AVENUE NO	DRTH		
		BROOKL	YN CENTER,	MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21980	Continued From pa	age 20	21980			
	reviewed R1's meo R1's Levaquin 750 administered incom between 5/26/17-5, recieved the medic other day for three Levaquin 750 mg o day. The NP consu physician. The NP had R1 sent to the evaluation. The NF discovered transcri Hospital records da treated for an overo unintentional and ir antiemetic medicat hospital. R1 returns evening with physic Levaquin for 48 hor	ated 5/31/17 indicated R1 was dose of antibiotic, accidental or ntravenous (IV) fluids and an ion was administered at the ed to the facility the same cian orders to hold the urs.				
	indicated a call was check the status of indicated R1 would later that night and R1's system at the	dated 5/31/17 at 9:13 p.m. s placed to the hospital to R1. The hospital nurse discharge back to the facility Levaquin was flushed out of hospital and new orders would Levaquin for 48 hours.				
		ated 6/1/17 at 1:27 a.m. Ind from the hospital before				
ppocet- D	indicated a transcri 5/26/17 and was no Levaquin 750 mg p entered on R1's MA	n Variance Report dated 6/8/17 ption error occurred between oted on 6/1/17 regarding R1's physician's order which was AR as Levaquin 750 mg every per day. The order was				

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If continuation sheet 21 of 24

STATEME	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00226	B. WING		C 08/16/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ATHA CARE CENTER	5409 691	H AVENUE NO	DRTH		
		BROOKL	YN CENTER,	MN 55429		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ae 21	21980	,		
	and double checke however the error v medication was add period of six days. medication error wa On 7/27/2017, R1's and indicated Levad six times per day or 5/30/17 to R1 for a administered by five Interview with the D 7/27/17 at 1:45 p.m medication was tran administered incorr was not reported to she identified the m when informed by the signed R1's Medica and indicated the en- because the medica had to be treated at	May 2017 MAR was reviewed quin 750 mg was administered of 5/26/17, 5/28/17, and total of 18 doses and e different staff members. Firector of Nursing (DON) on . confirmed the R1's nscribed incorrectly and ectly by staff and the error the SA. The DON confirmed redication error on 6/1/17 he NP of the error. The DON tion Variance report 6/8/17 rror as a significant error due ation was an antibiotic and R1 the hospital for an antibiotic ng to facility policy, the error				
	admitted to the facili included Alzheimer' condition where the are scarred and dar physician's orders of identified R2 had ph medication for Doxy antibiotic) 100 millig per day by mouth for	dical record identified R1 was hity with diagnoses which s disease, bronchiectasis (a bronchial tubes of the lungs maged), and dementia. R2's lated November 2016 hysician orders for profilactic /cycline Hydrochloride (an grams (mg) one capsule twice or the first 10 days of every infection. The November				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00226	B. WING			C 08/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE			
MARANA	ATHA CARE CENTER		H AVENUE NO YN CENTER, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	ge 22	21980	e tanta ana			
	November 2016 ph profilactic antibiotic Sulfamethoxazone/ 800/160 mg one tal 10 days of every thi The physician order the antibiotic was d R2's January 2017 indicated R2 reciev prescribed. R2's MAR for Marcl indicated R2 did no days of Doxycycline 2017 or the prescrift Sulfamethoxazone/ for a total of 20 mis A Medication Variar indicated R2 did no Doxycycline Hydroc prescribed Sulfame April 2017. The rep the antibiotic correct leading to the missi	Trimethoprim (an antibiotic) b one time per day for the first ird month for lung infection. rs indicated the next round of ue in February 2017. and February 2017 MAR ed the medication as h 2017 and April 2017 t recieve the prescribed 10 e Hydrochloride for March					
	indicated R2 did no missing the March a antibiotic doses. R2	nd April 2017 progress notes t have noted side effects from and April 2017 prescribed 2's May 2017 progress notes d away on 5/27/2017 from end Disease.					
	confirmed she had	ON on 7/27/17 at 1:45 p.m. found R2's medication errors nthly antibiotics for an					

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00226	B. WING	*		C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE		
MARANA	ATHA CARE CENTER		TH AVENUE NO			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	COBRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
21980	Continued From pa	age 23	21980			
	identified R2's med it may have caused she did not report t it was facility policy medication errors. A facility Vulnerable Policy dated April 2 of medical neglect problems, prescribe under potential indi excess drugging, la misuse" of medicat indicated all allegat vulnerable	g. The DON stated she lication error as significant as d actual harm and indicated he medication error, although to report significant e Adult Abuse Prevention Plan 017 identified under examples "not taking action on medical ed treatment or therapies" and cators of neglect "signs of ack of medication, or othe tion. The policy further tions of maltreatment against a				
	The administrator, review and revise a procedures regardi reporting/investigat maltreatment. The designee (s) could appropriate staff or procedures. The a designee (s) could abuse and or negle directed by the poli	THOD OF CORRECTION: DON, or designee (s) could as necessary the policies and ng the internal process of ing the process of abuse or administrator, DON, or provide training for all these policies and dministrator, DON, or monitor to assure all reports or oct are being reported as cy. CORRECT: Twenty-one (21)	f			

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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 <u>only a suggestion</u> 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. Maranatha Care Center September 14, 2017 Page 2 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,

Kumala Piske 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: <u>kamala.fiske-downing@state.mn.us</u>

Enclosure(s) cc: Licensing and Certification File Home Care & Assisted Living File Maranatha Care Center September 14, 2017 Page 3

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