MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Mission Nursing Home		**Report Number:** H5546053	**Date of Visit:** February 15, 2017
Facility Address: 3401 East Medicine Lake Blvd		**Time of Visit:** 9:45 a.m. to 6:00 p.m.	**Date Concluded:** December 29, 2017
Facility City: Plymouth		**Investigator's Name and Title:** Arthur Biah, RN, Special Investigator	
State: Minnesota	**ZIP:** 55441	**County:** Hennepin	

☒ **Nursing Home**

Allegation(s):

It is alleged that neglect occurred when a resident did not receive medication as ordered, and as a result, had several seizures.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on preponderance of evidence, neglect did occur. The facility licensed staff did not administer the resident's anti-seizure medication (Keppra), the resident suffered multiple seizures, had an unwitnessed fall, bit his/her lip and tongue, required manual breathing with Ambu (breathing) bag, and was hospitalized for six days.

The resident was admitted to the facility for long-term care with diagnoses of stroke, seizure disorder, and dementia. The resident had cognitive impairment with inability to completely express his needs without assistance. The resident had history of seizures that was controlled with anti-seizure medication, Keppra. The resident's physician's order indicated the resident was prescribed Keppra liquid of 1000 milligrams/ milliliters (mg/ml) to be administered twice daily. The resident had no other anti-seizure medication or therapy ordered. The resident's medication administration record indicated staff administered the medication to the resident as ordered. The record indicated the resident had not refused to take his/her medication for the past two months.

At close to midnight on the day of the incident, the resident was assisted to bed at bedtime and the bed was in the lowest position. During a routine night round, a facility's staff found the resident on the floor,

near his/her bed, and the resident was having a seizure. The staff notified the nurse immediately and the emergency medical services (EMS) was called. The staff stated the resident had another seizure as the EMS arrived. The EMS transferred the resident to the hospital for evaluation because of the seizures and the unwitnessed fall.

The hospital's medical record was reviewed and indicated the resident was admitted to the emergency department for seizures. The record indicated the resident's discharge diagnosis was low therapeutic Keppra level. The record indicated the resident had two additional seizures in the emergency room, was non-responsive to voice, and was assisted to breathe with Ambu (breathing) bag. The record indicated the resident appeared to have bitten his/her lip or tongue with blood around the mouth. The record indicated abnormal laboratory results (lactate 8.5, repeat 7.9; venous pH 7.14 with venous pCO2 31), which were interpreted as consistent with seizures. The Keppra level was very low at 2.4 micrograms/milliliter (mcg/ml); normal level 10-40 mcg/ml. The hospital administered a large dose of Keppra to the resident, followed by resumption of his/her usual dose twice daily.

The director of nursing was interviewed and stated after the resident's seizure, s/he investigated why the resident had seizures when s/he had been stable on the current regimen for about a year. The director of nursing found the resident's Keppra bottle contained 250 ml. The director of nursing stated with the resident's order for 10 ml of Keppra twice daily, the resident's Keppra bottle should have been empty two days before the incident. The director of nursing stated s/he interviewed staff responsible for the medication administration. All the staff interviewed indicated they administered the medication and could not explain why the resident's Keppra liquid did not seem to have been used as ordered. The director of nursing stated staff should have given the medication as ordered, document refusal in the resident's progress note if the resident had declined the medication, and notify the resident's physician as needed.

The hospital physician was interviewed and stated the resident was admitted to the hospital with seizures. The blood test for Keppra level was very low at 2.4 mcg/ml (normal expected range: 6-46 mcg/ml). The physician stated with the dosing of 1000 mg/ml twice a day, the low level meant the resident did not receive the medication. The physician attributed the resident's seizures to the low level of Keppra in the resident's blood at the hospital.

The resident was interviewed and did not recall the incident of seizure and the subsequent hospitalization.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation

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

Mitigating Factors:

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility's policy of medication administration was not implemented by multiple staff when a resident did not receive his/her medication as ordered and suffered seizures.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

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

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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

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

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

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

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] Medication Administration Records
- [x] Nurses Notes
- [ ] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports

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

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Two

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

Specify:

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

◉ Yes ○ No ○ N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

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

Specify:

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

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

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

◉ Yes ○ No ○ N/A Specify:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Five

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

Observations were conducted related to:

- [x] Nursing Services
- [x] Medication Pass
- [x] Cleanliness
- [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

Plymouth Police Department

Hennepin County Attorney

Plymouth City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	C 07/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5546053. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free of any significant medication errors for one of four residents, (R1), reviewed when staff did not administered R1's anti-seizure medication. R1 had seizures and was hospitalized for six days. Findings include: R1's medical record was reviewed. R1 was admitted to the facility with diagnoses with stroke, seizure disorder, and dementia. R1's brief interview for mental status (BIMS) completed January 9, 2016 indicated a score of 4 out of 15, indicating severe cognitive impairment. R1 needed staff assistance for medication administration to control his seizure. R1's care plan dated July 29, 2016 indicated R1	F 333		

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

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F 333	Continued From page 1 had history of seizure activity that resulted in a left humerus fracture. The care plan indicated R1 would have no seizure activity and instructed staff to administer medications as ordered. R1's physician order dated June 9, 2016 indicated R1 had an order for Keppra 100 milligrams/milliliter (mg/ml). The order indicated a start date of June 9, 2016 with dose of 1000 mg/10 ml to be administered twice a day for R1's seizure disorder. R1's laboratory record dated October 13, 2016 indicated R1 had a Keppra level of 8.1 micrograms/milliliter (mcg/ml); the normal expected range is 6-46 mcg/ml. R1's medication administration record (MAR) dated November and December 2016 indicated R1 was administered his anti-seizure medication and received the ordered dose of Keppra twice every day without any documented refusal. R1's pharmacy dispense history dated December 6, 2016 indicated the pharmacy delivered 473 ml of Keppra liquid to R1's facility. R1's pharmacist indicated in the dispense history that a quantity of 473 ml should last 23 days based on R1's physician order for 10 ml twice a day. R1's pharmacy dispense history dated December 27, 2016 indicated the pharmacy delivered 473 ml of Keppra liquid to R1's facility. R1's MAR for January 1, 2017 indicated R1 received the ordered dose for the anti-seizure medication on that day as prescribed. R1's nursing progress note dated January 2,	F 333		

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F 333	Continued From page 2	F 333		

2017 at 12:26 a.m. indicated R1 was found on the floor in his room having seizure on January 1, 2017 around 11:25 p.m. The note indicated R1 had foam coming from the mouth with the back and neck arched, lips blue, and breathing labored. R1 did not respond to verbal stimuli. Staff called the emergency medical services (EMS). The staff assessed R1 and applied oxygen until EMS arrived at the scene at 11:50 p.m. and transported R1 to the hospital at 12:10 a.m. The note indicated R1 had another seizure activity, lasting approximated 30-45 seconds, after EMS arrived.

The hospital medical record dated January 2, 2017 at 7:29 a.m. was reviewed and indicated R1 was admitted for seizures, noted to have bitten his lip/tongue with blood around his mouth and hospital staff manually assisted R1's breathing with Ambu (breathing) bag. R1 had additional two seizures and was given intravenous Keppra in the emergency room. The January 2, 2017 record indicated R1's laboratory results (lactate 8.5, repeat 7.9; venous pH 7.14, and venous pCO2 31) were consistent with seizure. The January 2, 2017 record indicated R1 had a very low level (2.4 mcg/ml); normal range is 6-46 mcg/ml) of Keppra in his blood at admission.

Hospital physician consultation note dated January 3, 2017 indicated R1 was seen by a neurologist for his seizures. The January 3, 2017 note the neurologist concluded R1's very low level of Keppra was most likely the reason for his seizure.

The facility's investigative report dated January 3, 2017 indicated R1 has had no seizure activity since admission January 19, 2016. The report

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F 333	Continued From page 3 indicated R1's had a 24-day supply (473 ml) of Keppra delivered on December 6, 2016 with order to administer 10 ml twice daily. With all doses signed by staff as administered, R1's bottle should have been empty on December 30, 2016. Instead of being empty, the December 6th Keppra bottle contained 250 ml of Keppra, indicating 223 ml was actually administered. The director of nursing (DON) was interviewed on February 15, 2017 at 5:11 p.m. and stated she conducted an investigation regarding R1's seizures. The DON stated R1's Keppra bottle should have been empty if staff had administered the medication according to the physician's order. The DON stated the facility did not had a process to monitor staff to ensure liquid medications are administered as ordered. R1's neurologist physician was interviewed on July 13, 2017 at 2:36 p.m. R1's physician stated the two reasons to explain R1's seizures were either R1 refused his Keppra as ordered or staff did not administer the medication as ordered. The physician stated R1's seizures and admission to hospital could be attributed to R1 not receiving his anti-seizure Keppra as ordered given the very level of the medication in his blood upon admission to the hospital. The facility's policy and procedure titled "Documentation" indicated drugs are to be given in strict accordance with the physician's most recent orders.	F 333		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5546053. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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

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21545	Continued From page 2 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free of any significant medication errors for one of four residents (R1) reviewed when staff did not administered R1's anti-seizure medication. R1 had seizures and was hospitalized for six days. Findings include: R1's medical record was reviewed. R1 was admitted to the facility with diagnoses with stroke, seizure disorder, and dementia. R1's brief interview for mental status (BIMS) completed January 9, 2016 indicated a score of 4 out of 15, indicating severe cognitive impairment. R1 needed staff assistance for medication administration to control his seizure.	21545		

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21545	Continued From page 3 R1's care plan dated July 29, 2016 indicated R1 had history of seizure activity that resulted in a left humerus fracture. The care plan indicated R1 would have no seizure activity and to administer medications as ordered. R1's physician order dated June 9, 2016 indicated R1 had an order for Keppra 100 milligrams/milliliter (mg/ml). The order indicated a start date of June 9, 2016 with dose of 1000 mg/10 ml to be administered twice a day for R1's seizure disorder. R1's laboratory record dated October 13, 2016 indicated R1 had a Keppra level of 8.1 micrograms/milliliter (mcg/ml); normal expected range is 6-46 mcg/ml. R1's medication administration record (MAR) dated November and December 2016 indicated R1 was administered his anti-seizure medication and received the ordered dose of Keppra twice every day. R1's MAR for January 1, 2017 indicated R1 received the ordered dose for the anti-seizure medication on that day as prescribed. R1's nursing progress note dated January 2, 2017 at 12:26 a.m. indicated R1 was found on the floor in his room having seizure on January 1, 2017 around 11:25 p.m. The note indicated R1 had foam coming from the mouth with the back and neck arched, lips blue, and breathing labored. R1 did not respond to verbal stimuli. Staff called the emergency medical services (EMS). The staff assessed R1 and applied oxygen until EMS arrived at the scene at 11:50 p.m. and transported R1 to the hospital at 12:10	21545		

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21545	Continued From page 4 a.m. The note indicated R1 had another seizure activity, lasting approximated 30-45 seconds, after EMS arrived. The hospital medical record dated January 2, 2017 at 7:29 a.m. was reviewed and indicated R1 was admitted for seizures, noted to have bitten his lip/tongue with blood around his mouth and hospital staff manually assisted R1's breathing with Ambu (breathing) bag. R1 had additional two seizures and was given intravenous Keppra in the emergency room. The January 2, 2017 record indicated R1's laboratory results (lactate 8.5, repeat 7.9; venous pH 7.14, and venous pCO2 31) were consistent with seizure. The January 2, 2017 record indicated R1 had a very low level (2.4 mcg/ml); normal range is 6-46 mcg/ml) of Keppra in his blood at admission. Hospital physician consultation note dated January 3, 2017 indicated R1 was seen by a neurologist for his seizures. The January 3, 2017 note the neurologist concluded R1's very low level of Keppra was most likely the reason for his seizure. The facility's investigative report dated January 3, 2017 indicated R1 has had no seizure activity since admission January 19, 2016. The report indicated R1's had a 24-day supply (473 ml) of Keppra delivered on December 6, 2016 with order to administer 10 ml twice daily. With all doses signed by staff as administered, R1's bottle should have been empty on December 30, 2016. Instead of being empty, the December 6th Keppra bottle contained 250 ml of Keppra, indicating 223 ml was actually administered. The director of nursing (DON) was interviewed on February 15, 2017 at 5:11 p.m. and stated she	21545		

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	00235	A. BUILDING: _____ B. WING _____	C 07/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 5 conducted an investigation regarding R1's seizures. The DON stated R1's Keppra bottle should have been empty if staff had administered the medication according to the physician's order. The DON stated the facility did not had a process to monitor staff to ensure liquid medications are administered as ordered. R1's neurologist physician was interviewed on July 13, 2017 at 2:36 p.m. R1's physician stated the two reasons to explain R1's seizures were either R1 refused his Keppra as ordered or staff did not administer the medication as ordered. The physician stated R1's seizures and admission to hospital could be attributed to R1 not receiving his anti-seizure Keppra as ordered given the very level of the medication in his blood upon admission to the hospital. The facility's policy and procedure titled "Documentation" indicated drugs are to be given in strict accordance with the physician's most recent orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21545		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act.	21850		

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21850	Continued From page 6 "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents are free from maltreatment for one of four residents (R1) reviewed when staff did not administered R1's anti-seizure medication, suffered an unwitnessed fall and was hospitalized for six days. Findings include: The facility's policy and procedure titled " Abuse Prevention and Prohibition: Resident Rights" indicated all employees are responsible for assuring that all residents are free of maltreatment. The facility's policy and procedure titled "Documentation" indicated drugs are to be given in strict accordance with the physician's most recent orders. R1's medical record was reviewed. R1 was admitted to the facility with diagnoses with stroke, seizure disorder, and dementia. R1's brief interview for mental status (BIMS) completed	21850		

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21850	Continued From page 7 January 9, 2016 indicated a score of 4 out of 15, indicating severe cognitive impairment. R1 needed staff assistance for medication administration to control his seizure. R1's care plan dated July 29, 2016 indicated R1 had history of seizure activity that resulted in a left humerus fracture. The care plan indicated R1 would have no seizure activity and to administer medications as ordered. R1's physician order dated June 9, 2016 indicated R1 had an order for Keppra 100 milligrams/milliliter (mg/ml). The order indicated a start date of June 9, 2016 with dose of 1000 mg/10 ml to be administered twice a day for R1's seizure disorder. R1's laboratory record dated October 13, 2016 indicated R1 had a Keppra level of 8.1 micrograms/milliliter (mcg/ml); normal expected range is 6-46 mcg/ml. R1's medication administration record (MAR) dated November and December 2016 indicated R1 was administered his anti-seizure medication and received the ordered dose of Keppra twice every day. R1's MAR for January 1, 2017 indicated R1 received the ordered dose for the anti-seizure medication on that day as prescribed. R1's nursing progress note dated January 2, 2017 at 12:26 a.m. indicated R1 was found on the floor in his room having seizure on January 1, 2017 around 11:25 p.m. The note indicated R1 had foam coming from the mouth with the back and neck arched, lips blue, and breathing labored. R1 did not respond to verbal stimuli.	21850		

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21850	Continued From page 8 Staff called the emergency medical services (EMS). The staff assessed R1 and applied oxygen until EMS arrived at the scene at 11:50 p.m. and transported R1 to the hospital at 12:10 a.m. The note indicated R1 had another seizure activity, lasting approximated 30-45 seconds, after EMS arrived. The hospital medical record dated January 2, 2017 at 7:29 a.m. was reviewed and indicated R1 was admitted for seizures, noted to have bitten his lip/tongue with blood around his mouth and hospital staff manually assisted R1's breathing with Ambu (breathing) bag. R1 had additional two seizures and was given intravenous Keppra in the emergency room. The January 2, 2017 record indicated R1's laboratory results (lactate 8.5, repeat 7.9; venous pH 7.14, and venous pCO2 31) were consistent with seizure. The January 2, 2017 record indicated R1 had a very low level (2.4 mcg/ml); normal range is 6-46 mcg/ml) of Keppra in his blood at admission. Hospital physician consultation note dated January 3, 2017 indicated R1 was seen by a neurologist for his seizures. The January 3, 2017 note the neurologist concluded R1's very low level of Keppra was most likely the reason for his seizure. The facility's investigative report dated January 3, 2017 indicated R1 has had no seizure activity since admission January 19, 2016. The report indicated R1's had a 24-day supply (473 ml) of Keppra delivered on December 6, 2016 with order to administer 10 ml twice daily. With all doses signed by staff as administered, R1's bottle should have been empty on December 30, 2016. Instead of being empty, the December 6th Keppra bottle contained 250 ml of Keppra,	21850		

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21850	Continued From page 9 indicating 223 ml was actually administered. The director of nursing (DON) was interviewed on February 15, 2017 at 5:11 p.m. and stated she conducted an investigation regarding R1's seizures. The DON stated R1's Keppra bottle should have been empty if staff had administered the medication according to the physician's order. The DON stated the facility did not had a process to monitor staff to ensure liquid medications are administered as ordered. R1's neurologist physician was interviewed on July 13, 2017 at 2:36 p.m. R1's physician stated the two reasons to explain R1's seizures were either R1 refused his Keppra as ordered or staff did not administer the medicaiton as ordered. The physician stated R1's seizures and admission to hospital could be attributed to R1 not receiving his anti-seizure Keppra as ordered given the very level of the medication in his blood upon admission to the hospital. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21850		