MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
The Legacy of St. Michael	HL27112004	July 6, 2017
Facility Address:	**Time of Visit:**	**Date Concluded:**
4400 Lange Avenue NE	8:50 a.m. to 4:20 p.m.	September 15, 2017
Facility City:	**Investigator's Name and Title:**	
St. Michael	Amy Hyers, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55376	Wright

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that a client was neglected when staff failed to provide the client's scheduled medications, which was prescribed for the client's multiple myeloma, resulting in worsening pain and increased clinic visits. The client's missing medications has been an ongoing issue.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

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

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect is substantiated. The client did not receive a prescribed chemotherapy medication for 26 of 42 scheduled doses due to medication errors, computer transcription error, and inadequate communication with the pharmacy. The blood work indicated the client was unable to reach a therapeutic range of chemotherapy to effectively treat the disease.

The client received services from a provider licensed as a comprehensive home care provider, including medication management. The client's diagnoses included a type of blood cancer. The client received a chemotherapy medication with a strict administration pattern, which required it to be given at the same time daily for 14 days, then off for one week, with that pattern repeating.

The client was not given 26 of 42 scheduled doses of the chemotherapy medications over a 12 week time-frame. The client went weekly to the cancer center to receive a second form of chemotherapy meant to be given concurrently with the oral form the home care provider was administering. Labs were also performed at the clinic, which indicated sub-therapeutic values.

Initially, the chemotherapy medication required special screening of the client by a pharmacist prior to

mailing the medication, which resulted in delayed delivery. The medication was unavailable for the nurse to administer. In another instance, a nurse failed to take the medication off hold status, resulting in several missed doses. There was a second occurrence of the medication not being available for administration. Another error occurred when a nurse changed a time setting in the computer causing the order to drop off.

During an interview, the family stated the client was never responsible for the ordering of the medications. Family also stated the home care provider only notified them of one instance when the client missed one week of medication.

During interviews, several nurses stated chemotherapy medications will be handled differently in the future. The home care provider had already initiated some of those changes.

During an interview, a nurse practitioner from the cancer center said the chemotherapy regime never had a chance to work. The nurse practitioner said the client passed away sooner than expected because s/he did not receive the chemotherapy medication as prescribed.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☒ Neglect ☐ Financial Exploitation

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

Mitigating Factors:

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

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

Although a system was in place to ensure accurate medication administration to clients, the home care provider failed to ensure staff followed the policy and procedure and several medication errors occurred.

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 Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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] 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] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: None

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: Resident is deceased

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: Resident is deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: None

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: No AP identified

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] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [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 - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Wright County Medical Examiners

Wright County Sheriff
Wright County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27112	A. BUILDING: _____ B. WING _____	C 07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST MICHAEL	4400 LANGE AVENUE NORTHEAST SAINT MICHAEL, MN 55376

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On July 6, 2017, a complaint investigation was initiated to investigate complaint #HL27112004. At the time of the survey, there were 97 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. 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.	
0 315 SS=H	144A.44, Subd. 1(12) Served by People Who Are Competent Subdivision 1. Statement of rights. A person who	0 315		

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0 315	Continued From page 1 receives home care services has these rights: (12) the right to be served by people who are properly trained and competent to perform their duties; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the clients' right to be served by people who were properly trained and competent to perform their duties when an interim staffing agency licensed practical nurse (LPN)-E was not oriented to the comprehensive home care services or facility medication management policy and procedures. This resulted in a pattern of medication set-up and administration errors for one of one clients (C1). This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death.), and is issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). Findings include: Record review indicated C1 received comprehensive home care services, including medication management according to a level of care form dated September 7, 2016 and a service plan dated April 3, 2017. Diagnoses for C1 included Multiple Myeloma (a form of blood cancer). Medication orders included Revlimid (a chemotherapy medication) 25 milligrams with strict orders to give 1 capsule at the same time daily for 14 days, then off for one week, then	0 315		

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0 315	Continued From page 2 repeat the cycle according to a physician's order dated April 7, 2016. C1's November 2016 to January 2017 medication administration record (MAR)s were reviewed, and 26 of 42 scheduled doses of Revlimid were not given to C1. Document review of medication error reports between November 2016 to January 2017 indicated LPN-E had six medication error reports for C1 that consisted of 10 actual medication errors in the medication set-up process. Document review of LPN-E's employee file lacked the document titled "Competency Evaluation Checklist ALF Licensed Staff"; a form utilized for training of licensed personnel. The document was completed for the LPNs employed directly by the licensee. On July 6, 2017 at 2:40 p.m. the director of health services, registered nurse (RN)-B was interviewed and stated she was unsure if LPN-E had been trained specifically to the home care provider's mediset system. Further, she said LPN-E's competencies were done by the interim staffing agency and she had one week of direct peer shadowing with the licensee. On July 24, 2017 at 2:27 p.m. the LPN-E was interviewed and stated she shadowed a staff nurse for two days before she was on her own. TIME PERIOD FOR CORRECTION: Seven (7) days	0 315		

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0 325	Continued From page 3	0 325		
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, one of one client (C1) was neglected when the licensee failed to verify prescription medication was given according to physician orders, monitor and evaluate the medication use, and resolve ongoing medication errors. As a result C1 was unable to reach therapeutic levels for cancer treatment and passed away sooner than expected. This violation occurred as a level four violation (a violation that results in serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: Record review of C1 indicated C1 received comprehensive home care services, including medication management according to a level of care form dated September 7, 2016 and a service plan dated April 3, 2017. Diagnoses for C1 included Multiple Myeloma (a form of blood cancer), atrial fibrillation, and osteoarthritis. Medication orders included Revlimid (a chemotherapy medication) 25 milligram (mg) capsules, with strict orders to give one capsule at the same time daily for 14 days, then off for one	0 325		

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0 325	Continued From page 4 week; then repeat from an order dated April 7, 2016; Xarelto (a blood thinner used to treat atrial fibrillation by preventing blood clot formation) 20 mg give one tablet every day from an order dated April 1, 2016; and Calcitonin (slows bone loss) give one spray each day; alternate nostrils from an order dated March 14, 2016. C1's November 2016 to January 2017 medication administration record (MAR)s were reviewed; 26 of 42 scheduled doses of Revlimid were not given to C1. Document review of Medical Doctor (MD)'s dictation dated February 16, 2017 indicated C1's lab result "is likely from her not getting Revlimid as supposed to rather than progression of the disease." Document review of medication error reports and C1's MARs between November 2016 to January 2017 indicated 31 medication errors in the medication set-up process by nurses. Document review of medication error reports between February 2017 to June 2017 indicated there were five nurse related medication set-up errors to clients other than C1. Document review of C1's MAR from November 2016 to February 2017 contained an order for Calcitonin; use one spray in alternating nostril every day. MAR's indicated 22 times the medication was administered in the same nostril two or more consecutive days. No medication error reports were written for any of these errors. Document review of C1's MAR's from November 2016 to March 2017 indicated 18 instances when C1 was out of the building that her medications	0 325		

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0 325	Continued From page 5 were documented as "resident out of building" or "at chemo." No further documentation was found to show whether the medication was given upon C1's return. Document review of C1's medical record indicated C1 had weekly appointments out of the building for chemotherapy and lab draws at the cancer clinic. During an interview on July 13, 2017 at 3:22 p.m., certified nurse practitioner (CNP)-F, from the cancer center where C1 received her treatment, stated Revlimid was given in combination with another chemotherapy medication C1 received at the cancer clinic. CNP-F said in her opinion, because the Revlimid was never given as prescribed, the chemotherapy regime never had a chance to work. She also confirmed the only way to determine the effectiveness of the Revlimid was by a lab (blood draw) called an IGG (immunoglobulins) level myeloma marker. She also stated that when C1's IGG was reviewed, the levels were going up which supported the fact that C1 was not receiving the Revlimid as prescribed. CNP-F stated in her opinion not receiving the Revlimid contributed to C1 passing away sooner than expected. During an interview on July 6, 2017 at 3:20 p.m., registered nurse (RN)-C stated there were initial difficulties getting the medication sent from the specialty pharmacy due to required screening questions. RN-C also stated she believed the consecutive doses of Calcitonin in the same nostril constituted a medication error. During an interview on July 6, 2017 at 3:58 p.m., RN-D stated she called the pharmacy to obtain permission for her to provide the screening	0 325		

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0 325	Continued From page 6 questions allowing a more efficient delivery of the medication. RN-D stated she should have been more involved C1's medication process from the beginning and it was not acceptable to have that many missed doses of medication. During an interview on July 6, 2017 at 2:23 p.m., licensed practical nurse (LPN)-A stated medications were placed into small white envelopes, labeled with the name, dose, and time for clients to take medications out of the building. LPN-A said if a medication is missed due to a client leaving the building, a nurse should be in contact with the medical provider for further direction. LPN-A also said when a client receives medication management services the nurse contacts the pharmacy when one week of medications are left if the medications are not on an automatic refill program. During an interview on July 6, 2017 at 2:40 p.m., RN-B, the director of health services, stated if she had to do it again an RN would manage the chemotherapy medication. RN-B also stated she believed the consecutive doses of Calcitonin in the same nostril constituted a medication error. Document review of a policy titled "Medication Administration -Licensed Nurse" dated August 2014 indicated "Always know the medications that you are giving, what effects they have...If you are not sure about any medication, check your medication reference manual." Document review of a policy titled Medication and Supplies -Reordering" dated February 2015 indicated nursing staff will assist clients to make sure medications and supplies are ordered and available as needed.	0 325		

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0 325	Continued From page 7 Document review of a policy titled "Medication Administration: Medication Errors" dated July 2013 indicated a medication error occurs when one of the rights is not followed (right: drug, tenant, time, route, dose, documentation). Document review of a policy titled, "Medication Administration -Planned Leave of Absence" dated August 2014 indicated that for planned time away the responsible party must inform a licensed staff member of the facility at least seven days in advance of their expected leave of absence. It further indicates the client or client's representative should be given written information pertaining to the medication, it should be placed in an appropriate labeled container, include information on how to contact the home care provider, and be documented on the MAR to whom the medication was given. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		
0 815 SS=D	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other	0 815		

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0 815	Continued From page 8 rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure an employee file was maintained when utilizing an interim staffing agency licensed practical nurse (LPN)-E for one	0 815		

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0 815	Continued From page 9 of one employee records reviewed. This violation occurred as a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). Findings include: During an onsite investigation on July 6, 2017, personnel files were reviewed. The licensee failed to provide evidence that the interim staff member, LPN-E had a valid Minnesota Board of Nursing licensed practical nurse license. The licensee could not produce any records of training or orientation to the comprehensive home care license, a job description, performance review, required health screenings, or background check. LPN-E's employee file consisted of a signed contract for her employment dated October 28, 2016, a summary of the LPN-E's skills and work experiences, a clinical assessments proficiency conducted and provided by the interim staffing agency, and six medication error reports from errors made while employed with the licence. During an interview with the registered nurse (RN)-B, director of health services on July 6, 2017 at 2:40 p.m. she stated she was unaware of any further documentation about the interim LPN-E's employee file. She stated she provided all the information available. TIME PERIOD FOR CORRECTION: Twenty-one	0 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27112	A. BUILDING: _____ B. WING _____	C 07/21/2017

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0 815	Continued From page 10 (21) days	0 815		
0 920 SS=G	144A.4792, Subd. 5 Individualized Medication Mgt Plan Subd. 5. Individualized medication management plan. (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific client instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any client-specific requirements relating to documenting medication administration,	0 920		

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0 920	Continued From page 11 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to accurately manage medication services for one of one clients (C1) when they failed to verify the prescription medication was given according to physician orders, monitor and evaluate the medication use, resolve ongoing medication errors, and communicate effectively with the pharmacist. This violation occurred as a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: Record review of C1 indicated C1 received comprehensive home care services, including medication management according to a level of care form dated September 7, 2016 and a service plan dated April 3, 2017. Diagnoses for C1 included Multiple Myeloma (a form of blood cancer), atrial fibrillation, and osteoarthritis. Medication orders included Revlimid (a	0 920		

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0 920	Continued From page 12 chemotherapy medication) 25 milligram (mg) capsules, with strict orders to give one capsule at the same time daily for 14 days, then off for one week; then repeat from an order dated April 7, 2016; Xarelto (a blood thinner used to treat atrial fibrillation by preventing blood clot formation) 20 mg give one tablet every day from an order dated April 1, 2016; and Calcitonin (slows bone loss) give one spray each day; alternate nostrils from an order dated March 14, 2016. C1's November 2016 to January 2017 medication administration record (MAR)s were reviewed; 26 of 42 scheduled doses of Revlimid were not given to C1. Document review of Medical Doctor (MD)'s dictation dated February 16, 2017 indicated C1's lab result "is likely from her not getting Revlimid as supposed to rather than progression of the disease." Document review of medication error reports and C1's MARs between November 2016 to January 2017 indicated 31 medication errors in the medication set-up process by nurses. Document review of medication error reports between February 2017 to June 2017 indicated there were five nurse related medication set-up errors. Document review of C1's MAR from November 2016 to February 2017 contained an order for Calcitonin; use one spray in alternating nostril every day. MAR's indicated 22 times the medication was administered in the same nostril two or more consecutive days. No medication error reports were written for any of these errors.	0 920		

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0 920	Continued From page 13 Document review of C1's MAR's from November 2016 to March 2017 indicated 18 instances when C1 was out of the building that her medications were documented as "resident out of building" or "at chemo." No further documentation was found to show whether the medication was given upon C1's return. Document review of C1's medical record indicated C1 had weekly appointments out of the building for chemotherapy and lab draws at the cancer clinic. During an interview on July 13, 2017 at 3:22 p.m., certified nurse practitioner (CNP)-F, from the cancer center where C1 received her treatment, stated Revlimid was given in combination with another chemotherapy medication C1 received at the cancer clinic. CNP-F said in her opinion, because the Revlimid was never given as prescribed, the chemotherapy regime never had a chance to work. She also confirmed the only way to determine the effectiveness of the Revlimid was by a lab (blood draw) called an IGG (immunoglobulins) level myeloma marker. She also stated that when C1's IGG was reviewed, the levels were going up which supported the fact that C1 was not receiving the Revlimid as prescribed. CNP-F stated in her opinion not receiving the Revlimid contributed to C1 passing away sooner than expected. During an interview on July 6, 2017 at 3:20 p.m., registered nurse (RN)-C stated there were initial difficulties getting the medication sent from the specialty pharmacy due to required screening questions. RN-C also stated she believed the consecutive doses of Calcitonin in the same nostril constituted a medication error.	0 920		

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0 920	Continued From page 14 During an interview on July 6, 2017 at 3:58 p.m., RN-D stated she called the pharmacy to obtain permission for her to provide the screening questions allowing a more efficient delivery of the medication. RN-D stated she should have been more involved C1's medication process from the beginning and it was not acceptable to have that many missed doses of medication. During an interview on July 6, 2017 at 2:23 p.m., licensed practical nurse (LPN)-A stated medications were placed into small white envelopes, labeled with the name, dose, and time for clients to take medications out of the building. LPN-A said if a medication is missed due to a client leaving the building, a nurse should be in contact with the medical provider for further direction. LPN-A also said when a client receives medication management services the nurse contacts the pharmacy when one week of medications are left if the medications are not on an automatic refill program. During an interview on July 6, 2017 at 2:40 p.m., RN-B, the director of health services, stated if she had to do it again an RN would manage the chemotherapy medication. RN-B also stated she believed the consecutive doses of Calcitonin in the same nostril constituted a medication error. Document review of a policy titled "Medication Administration -Licensed Nurse" dated August 2014 indicated "Always know the medications that you are giving, what effects they have...If you are not sure about any medication, check your medication reference manual." Document review of a policy titled Medication and Supplies -Reordering" dated February 2015 indicated nursing staff will assist clients to make	0 920		

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0 920	Continued From page 15 sure medications and supplies are ordered and available as needed. Document review of a policy titled "Medication Administration: Medication Errors" dated July 2013 indicated a medication error occurs when one of the rights is not followed (right: drug, tenant, time, route, dose, documentation). Document review of a policy titled, "Medication Administration -Planned Leave of Absence" dated August 2014 indicated that for planned time away the responsible party must inform a licensed staff member of the facility at least seven days in advance of their expected leave of absence. It further indicates the client or client's representative should be given written information pertaining to the medication, it should be placed in an appropriate labeled container, include information on how to contact the home care provider, and be documented on the MAR to whom the medication was given. TIME PERIOD FOR CORRECTION: Seven (7) days	0 920		
0 945 SS=G	144A.4792, Subd. 10(a) Medication Mgt for Clients Away from Home Subd. 10.Medication management for clients who will be away from home. (a) A home care provider who is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's	0 945		

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0 945	Continued From page 16 individualized medication management plan. The policy and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse according to appropriate state and federal laws and nursing standards of practice; (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed 120 hours; (3) the client or client's representative must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and (5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider. This MN Requirement is not met as evidenced by:	0 945		

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0 945	Continued From page 17 Based on interview and record review, the licensee failed to ensure policies and procedures were followed for one of one client (C1) who received medication management services when the client for planned times away from home. The violation occurred as a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: C1's record was reviewed. C1 received comprehensive home care services, which included medication management according to a level of care form dated September 7, 2016 and a service plan dated April 3, 2017. Medication orders included Xarelto (blood thinner used to treat Atrial fibrillation by preventing blood clot formation) 20 milligrams (mg), one tablet daily according to a physician order dated April 1, 2016 scheduled at 4:00 p.m. according to C1's medication administration record (MAR) and Buspar (anti-anxiety medication) 15 mg, one tablet three times per day according to a physician order dated March 28, 2016 with a dose scheduled at 2:00 p.m. according to C1's MAR. Document review of C1's MAR's from November 2016 to March 2017 indicate 18 instances when C1 was out of the building that her medications were documented as "resident out of building" or "at chemo." No further documentation was found to show the medication was given upon C1's	0 945		

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0 945	Continued From page 18 return. C1 missed ten doses of her Buspar and eight doses of her Xarelto during the stated time-frame. Document review of C1's medical record indicates C1 had weekly appointments out of the building for chemotherapy and lab draws at the cancer clinic. During an interview on July 6, 2017 at 2:23 p.m., licensed practical nurse (LPN)-A stated medications are placed into small white envelopes, labeled with the name, dose, and time for clients to take medications out of the building. LPN-A said if a medication is missed due to a client leaving the building, a nurse should be in contact with the medical provider for further direction. During an interview on July 6, 2017 at 2:40 p.m., the director of health services, registered nurse (RN)-B stated an LPN should follow up and ask the primary provider what direction should be taken if a client missed a medication while out of the building. During an interview on July 6, 2017 at 3:20 p.m., RN-C stated there is a process in place with a formal written LOA (leave of absence) marked envelope that is used for clients to take medications with them out of the building. She also said there is an LPN on-site from 7:00 a.m. to 11:00 p.m. and they are the responsible party to get further direction from the medical provider when doses are missed. Document review of a policy titled, "Medication Administration -Planned Leave of Absence" dated August 2014 indicates that for planned time away the responsible party must inform a licensed staff	0 945		

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0 945	Continued From page 19 member of the facility at least seven days in advance of their expected leave of absence. It further indicates the client or client's representative should be given written information pertaining to the medication, it should be placed in an appropriate labeled container, include information on how to contact the homecare provider, and be documented on the MAR to whom the medication was given. TIME PERIOD FOR CORRECTION: Seven (7) days	0 945		
01135 SS=F	144A.4795, Subd. 6 Temporary Staff Subd. 6. Temporary staff. When a home care provider contracts with a temporary staffing agency excluded from licensure under section144A.471, those individuals must meet the same requirements required by this section for personnel employed by the home care provider and shall be treated as if they are staff of the home care provider. This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to ensure one of one contracted nurses of the interim staffing agency had a valid Minnesota nursing license and had the potential to affect all the clients. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	01135		

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01135	Continued From page 20 client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: During an onsite investigation on July 6, 2017 personnel files were reviewed. The licensee failed to provide evidence that licensed practical nurse (LPN)-E had a valid Minnesota Board of Nursing licensed practical nurse license. The licensee could not produce any records of training or orientation to the comprehensive home care license, a job description, performance review, required health screenings, or background check. LPN-E's employee file consisted of a signed contract for her employment dated October 28, 2016, a summary of the LPN-E's skills and work experiences, a clinical assessments proficiency conducted and provided by the interim staffing agency, and six medication error reports from errors made while employed with the licensee. During an interview with the registered nurse (RN)-B, director of health services on July 6, 2017 at 2:40 p.m. she stated she was unaware of any further documentation about LPN-E's employee file. She stated she provided all the information available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01135		
02015 SS=D	626.557, Subd. 3 Timing of Report	02015		

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02015	Continued From page 21 Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	02015		

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02015	Continued From page 22 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected neglect of a vulnerable adult to Common Entry Point when the facility made repeated medication errors for for one of one client (C1). The violation occurred as a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: Record review of C1 indicated C1 received comprehensive home care services, including medication management, according to a level of	02015		

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02015	Continued From page 23 care form dated September 7, 2016 and a service plan dated April 3, 2017. Diagnoses for C1 included Multiple Myeloma (a form of blood cancer). Medication orders included Revlimid (a chemotherapy medication) 25 milligrams with strict orders to give 1 capsule at the same time daily for 14 days, then off for one week, then repeat the cycle according to a physician's order dated April 7, 2016. C1's November 2016 to January 2017 medication administration record (MAR)s were reviewed; 26 of 42 scheduled doses of Revlimid were not given to C1. Record review of C1's medical chart produced a document titled "Revlimid / Chemotherapy Drug Information". Document indicated Revlimid is for cancer treatment and the response to therapy is done via blood work. During an interview on July 6, 2017 at 2:40 p.m., the director of health services, registered nurse (RN)-B stated she did not report the medication errors to Common Entry Point. She stated in hindsight she would have reported the medication errors. Document review of internal investigation dated May 22, 2017 indicated in December 2016 after 13 of 14 doses of Revlimid were missed, the decision to not report the error to Common Entry Point was made because C1 had no complaints of increased pain and her vitals remained stable. The internal investigation also indicated a second occurrence at the end of January 2017, with seven of the 14 doses of Revlimid missed with another documented statement that the decision was made not to report the errors to Common Entry Point as C1 had no increase in pain and	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27112	A. BUILDING: _____ B. WING _____	C 07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02015	Continued From page 24 vital signs remained stable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		