STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING _____ B. WING _____	03/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDENBROOK OF EDINA	6200 XERXES AVENUE SOUTH MINNEAPOLIS, MN 55423

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure physician-ordered nutritional interventions were provided to promote eating and weight gain for 1 of 3 residents (R1) reviewed for nutrition. Findings include: R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had severe cognitive impairment and required supervision with eating. Further, R1 weighed was recorded as 167 pounds (lbs) and she had not sustained weight loss equal to or greater than 5% of her body weight within the past month, or 10% or more within the past six months. R1's most recent Registered Dietitian - Nutrition Assessment - ESHC - V 5, dated 11/29/19, identified a space to record R1's weight, however, it was not completed and left blank. R1 consumed a regular texture diet and used no adaptive equipment at meals. Further, an estimated calorie need for R1 was listed which identified R1 should consume 1213-1577 kcal/day to maintain good nutrition and weight. A series of nutritional supplements were listed for R1 including Glucerna and Magic Cup(s), and R1 was recorded as having, . ongoing poor (oral) intake, appointment for feeding tube to be placed again has been made for mid-December. The assement identified staff would continue to monitor R1's food and fluid intakes, supplement acceptance and weight for changes. A subsequent Twin Cities Physicians note, dated 12/11/19, identified an order which read, Please provide (R1) with apple sauce, yogurt or canned fruit with each meal. A corresponding Evaluation and Management note, dated 12/11/19, identified R1 had adult failure to thrive (FTT) and she had a history of [REDACTED]. The physician dictation continued, Continue to offer variety of foods - today stated that she would eat applesauce, yogurt, toast. R1's nutritional care plan, revised 12/16/19, identified R1 had potential for alteration in her nutritional status due to inadequate meal intakes. A goal was listed which read, . will continue to eat independently through review date, along with several interventions including providing assistance to R1 as needed, and monitoring for signs or symptoms of malnutrition. The care plan lacked the physician ordered intervention which had been written on 12/11/19. On 3/23/20, at 12:10 p.m. the lunch meal service on R1's unit was observed. R1 was seated in a wheelchair at a table in the dining room and was provided a regular plate of food which consisted of baked Swiss chicken, mashed potatoes and a vegetable blend. R1 was not served or offered any applesauce, yogurt or canned fruit in accordance with her physician order [REDACTED]. R1 left the table having only consumed bites of the provided chicken and potatoes. A white meal ticket was placed next to R1's plate which was observed. The ticket identified R1's name along with her ordered diet including instructions which read, Chocolate Magic Cup, Applesauce or yogurt each meal. When interviewed on 3/23/20, at 1:09 p.m. nursing assistant (NA)-A stated R1 had poor oral intakes every since she's came, and her intake for each meal varied so staff try to give her encouragement as able. NA-A verified R1 had not been served any applesauce, yogurt or canned fruit for the lunch meal and stated staff only provide those items in the morning for breakfast and not with each meal afterwards. NA-A stated she was unaware where the directions came from to provide those items for each meal, however, he felt R1 didn't really eat the items even when provided. Further, NA-A stated she was unaware of any recent weight loss for R1. R1's Weight Summary, printed 3/23/20, identified R1's recorded weights as follows: 3/23/20 - 148.7 lbs 2/22/20 - 145.4 lbs 1/21/20 - 151.6 lbs 12/25/19 - 156.6 lbs When interviewed on 3/23/20, at 1:35 p.m. speech language pathologist (SLP)-A stated R1 was not currently on caseload for SLP, however, she had been in the past for her cognition and ways to increase her appetite, including finding and providing meal items she enjoyed and would eat. SLP-A stated she was unsure where the intervention came from pertaining to providing applesauce, yogurt or canned fruit with each meal, however, expressed any intervention to provide nutritional support for R1 would be important to implement. Further, SLP-A expressed the facility could use a different system for ensuring nutritional interventions get identified and implemented consistently. During interview on 3/23/20, at 1:46 p.m. licensed practical nurse (LPN)-B stated R1's appetite was up and down, and lunch was typically her best consumed meal. LPN-B reviewed R1's medical record and stated the nurse practitioner order, dated 12/11/19, directed to provide R1 with those items for each meal, and the staff should be providing them accordingly as they were like a supplement to her. On 3/23/20, at 2:24 p.m. registered nurse (RN)-B was interviewed and explained R1 had sustained a little bit of weight loss during her admission to the nursing home. RN-B reviewed R1's meal ticket, medical record and physician orders [REDACTED]. This was important to do so R1 didn't lose more weight. When interviewed on 3/23/20, at 2:34 p.m. registered dietician (RD)-A stated the listed items on R1's meal ticket should have been served. RD-A expressed there was an education issue which needed to be addressed, and the items were important to serve to R1 to help her maintain her overall nutritional status. A facility' policy on nutritional intervention was requested, however, none was received.
F 0757 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure physician ordered laboratory monitoring was completed to prevent complications and ensure therapeutic dosing for 1 of 1 residents (R4) reviewed who consumed [MEDICATION NAME] (an anti-convulsant medication) for [MEDICAL CONDITION]. This resulted in actual harm for R4 when they developed symptoms of [MEDICATION NAME] toxicity (a condition were the levels of medication in the body are too high) and were subsequently hospitalized . Findings include: R4's hospital Discharge Summary, dated 11/18/19, identified R4 had been brought to the hospital after being found obtunded (a state similar to lethargy) at her home. R4 was brought to the hospital were she was found, . in [DIAGNOSES REDACTED] (a single [MEDICAL CONDITION] more than five minutes or two or more [MEDICAL CONDITION] within a five-minute period without the person returning to normal between them) with elevated ([MEDICATION NAME] kinase; a lab value) and multiple fractures. R4 was admitted and subsequently discharged after seeing neurology with several new orders, including an order for [REDACTED].-anxiety medication), and [MEDICATION NAME] (a sedative). R4's 5-Day Minimum Data Set (MDS), dated [DATE], identified R4 had intact cognition and was independent with transfers and locomotion on and off the unit. Further, R4's [DIAGNOSES REDACTED]. On 3/24/20, at 9:33 a.m. R4 was interviewed. R4 explained she admitted to the nursing home in November 2019, from the hospital where she had been admitted due to developing new [MEDICAL CONDITION]. R4 stated when she discharged the hospital, and came to the nursing home, she was started on several medications including some which helped control her [MEDICAL CONDITION], including [MEDICATION NAME]. R4 expressed concern as she didn't think the [MEDICAL CONDITION] medication was being monitored correctly, and explained an incident had occurred about a month prior where she woke up feeling like I had bricks tied to my legs and could barely move or bear weight when she tried to stand up. R4 went to the Emergency Department (ED), and subsequently was hospitalized the following day, where they did some lab work and found the [MEDICATION NAME] level in her blood was way too high and she had, [MEDICATION NAME] toxicity. R4 stated she thought there had been some communication troubles between the nursing home and hospital which may have caused the incident, as the hospital told her they had tried getting ahold of the nursing home, however, couldn't get through to anybody. Further, R4 expressed since her hospitalization , her [MEDICATION NAME] monitoring had been going better as she was making sure it gets done. R4's Call Documentation note, dated 1/30/20, identified three separate, recorded entries which included: On 1/30/20, at 3:44 p.m., Message from (nurse practitioner (NP)-A) . Can you please call (nursing home) and let them know [MEDICATION NAME] level is low. Lets increase [MEDICATION

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

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

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F 0757 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) NAME] ER from 300 mg at (bedtime) to 200 mg (twice a day) and rechecke (sic) [MEDICATION NAME] free and total levels (laboratory tests to monitoring the [MEDICATION NAME] level in a patient) in 2 weeks. On 1/30/20, at 5:19 p.m., Spoke with (nursing home) reception and call was (transferred) to Nursing. No answer and phone continued to ring with no VM (voicemail). Telephone encounter order, lab orders, and medications order printed and faxed to (fax number). On 2/5/20, at 11:46 a.m., Spoke with Nurse at (nursing home) and orders faxed on 1/30/20 were not rec'd (received). Wrong fax# was provided. Correct fax is (number listed). Orders re-faxed per request. The note identified a section labeled, Approved, which provided instructions for [MEDICATION NAME] 200 mg by mouth twice a day to be started on 1/30/20. The order was listed as authorized by NP-A, and had a visible handwritten star shape next to it along with a handwritten, nursing home staff signature (registered nurse, RN-B). Further, the note contained a section labeled, Orders Placed This Encounter, which directed a [MEDICATION NAME] Free and [MEDICATION NAME] Total (two separate lab tests) be completed. The labs had two associated columns present which included, Expected By, and, Expires, with dates listed as 2/13/20, and 3/14/20, respectively. There was no additional, handwritten documentation or dictation next to the lab test(s) which identified they had been acted upon or placed for draw. R4's Medication Administration Record [REDACTED]. An order was listed which read, ([MEDICATION NAME] ER) . 300 mg orally at beditme related to EPILEPTIC [MEDICAL CONDITION] . with a listed start date of 11/21/19. This order was recorded as administered until 2/4/20. A subsequent order for [MEDICATION NAME] was listed which read, ([MEDICATION NAME] ER) . 200 mg by mouth two times a day ., and listed a start date of 2/5/20. The order was recorded as being administered to R4 from 2/5/20 to 2/20/20 at 8:00 p.m. when the medication was then recorded as, H (held). The medication was then recorded as being held for several doses. R4's medical record was reviewed and lacked evidence the ordered laboratory monitoring from NP-A on 1/30/20, had been acted upon, drawn or clarified to ensure accuracy and/or the therapeutic dosing of R4's [MEDICATION NAME]. Further, there was no evidence the facility had increased or implemented any additional monitoring of R4's [MEDICATION NAME] use despite having a dose increase on 2/5/20, nor was there evidence R4 had been offered and declined the requested laboratory test(s) on 1/30/20. R4's medical record identified the following notes and other entries: On 1/31/20, a progress note recorded R4 as having no cognitive impairment and being, Full weight bearing. On 2/9/20, a progress note recorded R4 as having no cognition impairments, however, now listed R4 as having a, Decline in functional status. The note lacked any specifics pertaining to what abilities had declined, nor any subsequent assessment or intervention of this decline. On 2/19/20, a progress note identified R4 complained of being more shaky than usual and having trouble walking or standing up. Family member (FM)-A came to pick R4 up for an orthopedic appointment and reported R4 seemed to be more confused in the past week with extra shakiness. FM-A expressed concern R4 could have had another [MEDICAL CONDITION]. FM-A told the nursing home they were going to attempt to see R4's neurologist after her orthopedic appointment. There were no further notes or dictation which identified if R4 had been seen by neurology or not, nor any subsequent assessment or action to address the newly identified symptoms. On 2/20/20, a progress note identified R4 was taken to the ED by FM-A to address the weakness, shaking [MEDICAL CONDITION] concerns. The note identified no new orders were given from the ED and FM-A reported the ED was unable to determine the cause of R4's symptoms. R4's corresponding Emergency Department Provider Notes, dated 2/19/20, identified R4 presented to the ED with, generalized weakness. R4 had been scheduled to discharge the nursing home that day (2/19/19), however, developed weakness and heaviness in her legs three hours ago. FM-A was present and reported R4 had shaking chills, so bad that she should (sic) not fully talk, prompting presentation to the emergency center. The note identified FM-A had reported R4 seemed to have an increase in confusion in the past few days, however, there had been no witnessed [MEDICAL CONDITION] today. A, Review of Systems, identified R4 as presenting with chills and diaphoresis along with being short of breath. An ECG (electrocardiogram) was completed which showed no significant changes from a previous reading. A series of laboratory tests were completed which identified a [MEDICATION NAME] level of 25.8, and listed the result as, H (high). A reference range was not identified. An additional [MEDICATION NAME], Free level was collected, however, the results were listed as, Pending. The note listed an, Impression and Plan, which included dictation reading, Her ([MEDICATION NAME]) level is slightly supra therapeutic however, did discuss with pharmacy and added on a free ([MEDICATION NAME]) level, as with her CKD, this is likely to be affecting this level and free level would be more accurate. The dictation concluded that no acute reason for R4's symptoms could be found and she was returned to the nursing home. Further, the note listed a section labeled, Lab - All Results, which identified R4's [MEDICATION NAME], Free laboratory result as 2.7 mcg/ml (micrograms per milliliter) and listed a reference range of 1.0 - 2.0 mcg/ml. This result was identified as, H /\ (high), and R4's [MEDICATION NAME] level was within the established reference range. A subsequent Conversation: Other note, dated 2/20/20, identified dictation completed by NP-A and outlined a discussion was held with FM-A regarding R4's increased bilateral leg weakness and shaking. The note identified, (NP-A) discussed with her that [MEDICATION NAME] level is elevated and her symptoms are likely [MEDICATION NAME] toxicity. The note listed several new orders for R4 which included a holding her scheduled [MEDICATION NAME] for several doses, obtaining new [MEDICATION NAME] levels and contacting the on-call neurologist with the results, and giving R4 as-needed [MEDICATION NAME] to help control the shakiness. On 2/20/20, a subsequent progress note identified R4 went to an appointment with FM-A, who then proceeded to take R4 back to the ED for a second time due to continued shakiness, weakness and confusion. The note identified R4 was subsequently admitted to the hospital for monitoring. R4's corresponding Abbott Northwestern Hospital Discharge Summary, dated 2/23/20, identified a principal [DIAGNOSES REDACTED]. The summary identified R4 presented to the Methodist ED on 2/19/20, for evaluation of leg weakness and chills. The Methodist ED completed laboratory test(s) which were remarkable for hemoglobin of 10.1 (normal range 12-15.5), creatinine of 1.23 (normal range 0.84 to 1.21) and [MEDICATION NAME] level of 25.8, and the note identified since no acute findings were present, R4 was discharged back to the nursing home and R4's neurologist was contacted who recommended lowering R4's [MEDICATION NAME] dosing given (the) elevated level. R4 was listed as presenting to the Abbott ED with ongoing bilateral leg heaviness and difficulty ambulating. An MRI was completed which was negative for stroke, and R4's [MEDICATION NAME] level remained elevated at 3.8 so her [MEDICATION NAME] was held. R4's [MEDICATION NAME] levels were listed as 2.1 (Free) on 15.1 (Total) on 2/23/20 and neurology felt that her symptoms were resolving. R4 was discharged from the hospital on [DATE], back to the nursing home. When interviewed on 3/24/20, at 10:45 a.m. registered nurse (RN)-A explained the nurse working when they receive orders or faxes from provider's were responsible to ensure any ordered laboratory test(s) were entered into the system to be completed. RN-A expressed she was unaware R4 had been hospitalized with [MEDICATION NAME] toxicity in the last month, and expressed she did not think [MEDICATION NAME] levels were drawn for residents residing at the nursing home. Further, when asked if she had received any education or training on [MEDICATION NAME] level monitoring since R4's hospitalization , RN-A responded, I don't want to answer. On 3/24/20, at 10:57 a.m. RN-B was interviewed and verified it was her signature on the Call Documentation note, dated 1/30/20, which directed to increase R4's dose of [MEDICATION NAME]. RN-B stated she could not recall if she acted on or ordered the laboratory testing which was requested on the form, however, expressed if she had ordered them then she would have done so using the electronic EMDEON system. RN-B reviewed this system, along with R4's medical record, and verified they lacked evidence the ordered laboratory testing and monitoring had been completed. RN-B stated R4 had been having complaints of chills well before her hospitalization in February 2020, however, acknowledged the sudden weakness and leg shakiness, which developed the day prior to her hospitalization with [MEDICATION NAME] toxicity, were new symptoms for R4 which she had not displayed before. RN-B stated the laboratory monitoring which had been ordered on [DATE], should have been completed timely so her dosing could have been adjusted and helped to prevent some of that (ED visits and hospitalization). RN-B stated the facility had issues getting laboratory testing done consistently, so they were implementing steps to change the process including having all incoming faxes come to just a single fax-machine and appointing one health unit coordinator (HUC) to oversee them. However, RN-B stated she had not personally had any re-education since R4's hospitalization regarding this process. On 3/24/20, at 11:23 a.m. a telephone call was attempted with FM-A. A return call was provided on 3/24/20, at 4:05 p.m. and FM-A stated R4 had been hospitalized because the facility wasn't monitoring her [MEDICAL CONDITION] medications and doing the needed blood draws. R4 went to the Methodist ED on 2/19/20, however, they couldn't find anything wrong with R4 despite her symptoms, however, the ED never really got back to us with their lab findings or told them her [MEDICATION NAME] level was elevated. R4's symptoms continued which caused FM-A to worry and bring her back to the hospital the following day on 2/20/20, where the physician told her R4's [MEDICATION NAME] level(s) were way too high, and R4's developed symptoms were likely due to [MEDICATION NAME] toxicity. On 3/24/20, at 1:13 p.m. NP-A was interviewed and reviewed R4's hospital medical record. FM-A had contacted the clinic on 2/17/20, and reported R4 was confused, shaky and sleepy. The hospital records identified the ordered laboratory monitoring from 1/30/20, had never been completed which they verified. R4 then went to the ED on 2/19/20, where the laboratory tests were completed. R4 then presented to the hospital

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F 0757 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) on [DATE], and was found to have likely [MEDICATION NAME] toxicity. NP-A explained R4 was hard to diagnose as they were trying to reduce her pain medications and she has displayed withdrawal symptoms which could mimic [MEDICATION NAME] toxicity, which is why the laboratory tests were ordered on [DATE]. NP-A stated if the ordered laboratory monitoring had been completed on 2/13/20, when it was ordered to be done, the levels would have been known sooner and NP-A would have done what Abbott (hospital) did and immediately reduce R4's dose so it didn't continue to go higher. NP-A explained she (couldn't) really say if R4's hospitalization could have been avoided had R4's laboratory tests been completed, however, added, Luckily (FM-A) took her to the ER. Further, NP-A stated she had issues before with getting ordered laboratory testing completed for patients while they reside at the nursing home adding the facility had been not super reliable in getting things done in the past. On 3/24/20, at 2:30 p.m. the director of nursing (DON) and licensed practical nurse manager (LPN)-A were interviewed and reviewed R4's medical record. DON expressed the written 'expected by' and 'expires' dates allowed the facility to obtain the laboratory tests between those dates. DON stated she did not consider the communication an actual order, either, as it was not physically or electronically signed by NP-A; however, DON added the nurse who received it should have clarified the intent of the note with the provider. DON stated if R4's [MEDICATION NAME] levels had been monitored more closely, the staff would have known she was getting too high sooner and it could have been addressed quicker. The DON expressed she did not know if R4's hospitalization could have been completely avoided, however, acknowledged R4's [MEDICATION NAME] levels could have been monitored closer as it was a critical medication, and they wanted to avoid negative outcomes. Further, DON acknowledged the facility had issues with getting ordered laboratory tests completed, however, they had been working on different systems to correct the issues including revising the orientation process for new nurses. However, they had not yet been able to educate all the current nurses with the progress and procedure changes. A provided Therapeutic Drug Monitoring policy, dated 2/21/19, identified a purpose which read, To provide guidance on laboratory monitoring in accordance with specific medication administration in accordance with recognized standards of practice and manufacturer recommendations. A procedure was listed which directed to obtain physician orders [REDACTED]. The laboratory tests will be monitored and communicated to the prescribing physician who will review them for any needed adjustments. Further, the policy included a table which outlined several medications with recommended laboratory testing. [MEDICATION NAME] was listed which listed a reference value range for 10-20 mcg/dl.