STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARONDELET VILLAGE CARE CENTER	525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medications were transcribed and administered per providers order for 1 of 3 residents (R1) reviewed for significant medication errors. This resulted in an immediate jeopardy (IJ) situation for R1 who received a dose of [MEDICATION NAME] (a narcotic [MEDICATION NAME]) sixteen times the dose ordered, resulting in unresponsiveness, [MEDICAL CONDITION] (low oxygen level) and respiratory distress. The physician ordered a medication to reverse the effects of the [MEDICATION NAME] overdose, the order was again transcribed incorrectly and a dose was administered to R1 less than what was ordered and via the wrong route of administration. This resulted in drowsiness and intermittent unresponsiveness, [MEDICAL CONDITION], and respiratory distress for R1 for over 24 hours. The immediate jeopardy began on 7/24/20, when two significant medication errors occurred for R1. The facility administrator, director of nursing (DON) and the facility campus administrator were notified of the immediate jeopardy at 3:51 p.m. on 7/29/20. The immediate jeopardy was removed on 7/30/20, but noncompliance remained at the lower scope and severity level of a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R1's significant change Minimum Data Set ((MDS) dated [DATE], included moderate cognitive impairment, required extensive to total assistance with most activities of daily living (ADL's), had pain daily at a level 8 (on a 0-10 scale with 0 being no pain and 10 being excruciating/unmanageable pain), had shortness of breath with exertion, and received an opioid (narcotic) medication 7 out of the 7 day look back period. R1 had [DIAGNOSES REDACTED]. R1's care plan dated 7/15/20, included a recent femur fracture, staff were directed to provide medications as ordered. Hospice care was added to the care plan on 7/20/20 for a [DIAGNOSES REDACTED]. DO NOT AWAKE TO GIVE MEDICATION. R1's Hospice progress note dated 7/24/20, 2:46 p.m. included, Writer reviewed EHR (electronic health record) and then spoke with facility nurse (name of nurse). She indicated that (R1's name) overall does not look good. She indicated that held 0800 (8:00 a.m.) dose of [MEDICATION NAME] as patient was asleep. Writer indicated that would remove part of the order that says HOLD IF ASLEEP. Writer instructed (nurse) regarding how to slide syringe inside cheek if asleep, and also giving a PRN (as needed) dose when awakens if scheduled dose held. In this way, will get caught up to base line dose, to manage symptoms. (Nurse) also indicated that patient is eating little. Writer informed her regarding family goal of decreasing [MEDICATION NAME] (an antipsychotic medication often used for agitation/hallucinations/delusions when in dying process), but we may need to increase [MEDICATION NAME] if pain persists at present dose. Family is concerned about her being so sleepy. Writer went to (R1's) room. (R1) was sitting in her Broda Chair (reclining chair) dozing. She did arouse when name was stated. (R1) acknowledged that writer was new; writer explained that patient has always been asleep with (sic) writer came into room. Patient stated, 'I don't feel good.' She could not elaborate on that, and did not reply to questions about pain, writer noted that resps (respiratory) rate was elevated at 28 BPM (breaths per minute/normal is 12-16) Asked patient if was having difficulty catching breath, patient stated yes. R1's new physician order [REDACTED]. However, the order was transcribed into the electronic medical record (EMR) and the Medication Administration Record [REDACTED]= 4 ml. This resulted in the [MEDICATION NAME] dose being 16 times higher than the dose actually ordered by the physician. Registered nurse (RN)-A signed off as double checking the order to ensure accuracy on 7/24/20, at 4:20 p.m. R1's progress note dated 7/25/20, at 1:44 a.m. and written by RN-A included, Writer gave 2 separate does of 4 mls of [MEDICATION NAME] to resident. First dose at 1640 (4:40 p.m.), second dose at 2100 (9:00 p.m.) 8 mls in total given to resident when it should have been 0.5 ml give for entire evening shift. Order was entered incorrectly in PCC (Point Click Care, the facilities EMR); writer confirmed incorrect order and that is how medication error occurred. 2330 (11:30 p.m.) is when NOC (night) nurse went to go check on resident and found her RR (respiratory rate) 6-8 per minute (normal 12-16), HR (heart rate) 74 (normal 60-100) and 02 sats (oxygen level) 77% (normal 95-100%). Noc nurse put resident on 2.5 liters of 02 (oxygen) via nasal cannula. Resident 02 went to 90% and later to 98%. Writer called hospice to inform of error and resident condition. Writer corrected error in PCC (the EMR) to reflect correct dosing of 0.25 mls per 4 hours. Writer received order to give 2mg of [MEDICATION NAME] (a narcotic reversal medication) STAT (immediately) injection to resident, up to 10 mgs, until rousable and to proceed with 15 minute checks 8 times for 2 hours, then checks every hours for 6 hours. Resident was rousable after one administration. Writer then called POA (power of attorney) about error and resident condition. Resident is currently on 2.5 liters of O2, sats are 97%. RR 16-18 per minute. Pulse 75. R1's Presbyterian Homes Hospice order dated 7/25/20, at 12:42 a.m. included, [MEDICATION NAME] 2 mg IM (in the muscle) now- May be repeated every 2-3 minutes, as needed until client is rousable, with max dose of 10 mg. VS (vital signs) checks q (every) 15 min. (minutes) x 8 then VS checks q 1 hr (hour) x 6. Call EMS (emergency medical services) for additional support if not arousable, or to get additional [MEDICATION NAME], or if not able to get [MEDICATION NAME]. However, the orders was transcribed by RN-A as, [MEDICATION NAME]. Route inj (injection), Dose: 2 mg to 10 mg. Frequency 2 mg to 10 mg, Diagnosis: [REDACTED]. The order as transcribed failed to indicate the 2 mg could be repeated every 2-3 minutes up to a total dose of 10 mg along with the omission of vital signs transcribed or to call EMS if correct dose of [MEDICATION NAME] was not available. R1's progress note dated 7/25/20, at 7:27 a.m. included, Resident VS checked QH (every hour) through the night and remained stable. RR (respiratory rate) 16/min visually observed; O2 sats 94-97% 2.5L NC (nasal cannula). No periods of apnea (temporary cessation of breathing) observed. Resident rouses easily when name spoken and verbally responds appropriately to simple yes/no questions. No additional scheduled [MEDICATION NAME] administered during the night. R1's Medication Variance Report dated 7/25/20, indicated R1 did not receive the correct dose or route of the [MEDICATION NAME]. The [MEDICATION NAME] had been taken from the emergency kit, which only contained [MEDICATION NAME] 0.4 mg/ml and only 1 ml had been given to R1. The report indicated RN-A had given the 0.4 mg of [MEDICATION NAME] with a [MEDICATION NAME] syringe, in which the needle is made to inject medication under the skin, not into the muscle as ordered. In addition, the [MEDICATION NAME] had not been ordered from the pharmacy and therefore not available when needed in the morning for R1 when she became unresponsive again with periods of apnea. R1's progress note dated 7/25/20, 4:08 p.m. included, 7:30 a.m. Night shift reported to writer that resident is arousable and respiration is 16 b/m (breaths per minute); and response to yes or no questions. 7:45-10:00 a.m. writer took the full set of vital signs; respirations: 8-10 b/m, oxygen saturation: 94% on 2l/min (2 liters per minute) oxygen; BP (blood pressure) 110/70; t-(temperature) 98.2; p-(pulse) 76 b/m (beats per minute); hospice nurse was informed about the residents ongoing health condition and informed that she did not get the proper dose of [MEDICATION NAME]; [MEDICATION NAME] was ordered from the pharmacy as a stat (immediate) order however the pharmacy told that it will take 2 hr (hours) for the process and arrival; family members was informed regarding the resident ongoing health condition and and (sic) give the option if she would like to send the resident to the hospital; responsible party told that she would like (sic) rely on the decision of the hospice nurse and would like to meet with the hospice nurse; hospice nurse was informed that family member want to meet the hospice nurse and leave the decision of the resident to the hospice nurse; hospice nurse arrived around 10:20 and family member was informed about the arrival of the nurse. R1's progress note dated 7/25/20, 2:12 p.m. included, 10:30 a.m. Seen resident not arousable accompanied by hospice nurse; hospice nurse stayed with resident in room; received information that hospice nurse

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0760

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)

is waiting for family member to come in and make decision if resident will be sent to ER (emergency room) or not. 10:50 a.m. Resident's POA (power of attorney) arrived; made the decision of not to admit the resident to the hospital and to wait for the [MEDICATION NAME] (brand name for [MEDICATION NAME]) to be delivered; clinical administrator and clinical administrator (sic) was aware. Writer followed up with pharmacy re: time of arrival of [MEDICATION NAME] and pharmacist informed writer that they are processing it and will be sent ASAP. R1's progress note dated 7/25/20, 11:00 a.m. included, Writer checked with AL (assisted living) clinical administrator for availability of [MEDICATION NAME] in their E-kit; AL clinical administrator informed writer to check their medication room; found [MEDICATION NAME] nasal spray in their medication cart, called AL clinical administrator again to inform and gave a go signal to use it if appropriate. 11:05 a.m. Writer approached hospice nurse and asked that since [MEDICATION NAME] medication from pharmacy is still not available, if we can use the [MEDICATION NAME] Nasal Spray; hospice nurse verbalized, I will secure the order later for the spray. 11:10 a.m. Hospice nurse administered 4 mg of [MEDICATION NAME] Nasal Spray, writer present as witness. 11:25 a.m. Resident became responsive and conversant; accompanied by sister in room. 12:45 p.m. [MEDICATION NAME] injection was received from pharmacy; writer verified with hospice nurse if (sic) which form of [MEDICATION NAME] (spray or injection) is to be given; hospice nurse confirmed to stick with the using the spray as indicated in the recent orders. R1's progress note dated 7/25/20, 1:00 p.m. included, Resident drank approximately 60 cc (cubic centimeters) of apple juice and ate a small portion of the cherry cake as reported by hospice nurse and her sister. 1:30 p.m. Hospice nurse reported that she increase O2 @ 5 lpm via nasal cannula; resident is resting comfortably, sleepy but she is arousable to speech and touch; able to make short verbal responses. 2:10 p.m. Resident is responsive to speech and touch; still accompanied by her sister. R1's progress note dated 7/25/20, 4:00 p.m. included a respiratory rate of 12, oxygen level 90% on oxygen at 5 lpm, and resident was not arousable. 5:40 p.m. unable to open mouth for supper. 6:30 p.m. unable to arouse. 7:30 sleeping, respiratory rate of 12 and oxygen level of 99%. 9:00 p.m. R1 was not arousable. opened one eye during bed bath and made a noise. 10:20 p.m. respirations had dropped to 8 and the [MEDICATION NAME] was administered again. 11:00 p.m. unable to arouse and all medications had been held. Although R1 had received doses of [MEDICATION NAME], she continued to have symptoms of respiratory depression and unresponsiveness as a result of the medication error. R1's progress note dated 7/26/20, 7:29 a.m. noted respirations stable through the night, no apnea and did respond verbally when spoken to. When interviewed on 7/28/20, at 2:30 p.m. HIMS-A stated RN-D had written a verbal order for the change in [MEDICATION NAME] on 7/24/20, HIMS-A transcribed the order into the EMR (Point Click Care). However, the order was written as [MEDICATION NAME] 20 mg/ml, 5 mg every 4 hours, there was no milliliter equivalent and the PCC system would not take the order unless there was a milliliter designated for the amount. HIMS-A stated she did the math/drug calculation, by dividing the 20 mg by the 5 mg and came up with 4 milliliters, but was unsure she had calculated this correctly. She had never been trained to calculate drug doses, so she had RN-B review it and RN-B said it was good. She identified it is the facility policy to have a nurse check off on any orders processed by an HIMS, so RN-A signed off on the order later in the shift. When interviewed on 7/28/20, at 12:45 p.m. RN-A stated, she had seen the order for R1's [MEDICATION NAME] in the computer as needing a nurse to sign off on it, she had assumed the dosage calculation had been done correctly and signed off on it without doing the dosage calculation herself. I just signed what (HIMS-A) had written. RN-A stated she had given R1 the incorrect dose of [MEDICATION NAME] as it was transcribed, the 4 ml to equal 80 mg twice during her shift, not noting the discrepancy. When the night shift came on duty they did a narcotic count together and the night nurse (RN-D) noted there was too much [MEDICATION NAME] used and checked on R1 who was unresponsive and having apnea with respirations of only 8 per minute. This was how they found the medication error. She called hospice to report the error and R1's condition. Hospice returned the call and ordered the [MEDICATION NAME], she processed the order and administered the [MEDICATION NAME] to R1 who then became responsive and no longer had apnea. RN-A did not find out she had transcribed the order wrong for the [MEDICATION NAME] or that she had given the wrong dose, using the wrong type of syringe until the next day. She used 2 -1 ml [MEDICATION NAME] syringes and used the vial of [MEDICATION NAME] from the emergency kit, she did not recognize it was only 0.4 mg instead of the 2 mg ordered. RN-A did not order the STAT [MEDICATION NAME] from the pharmacy, since this medication was already in the emergency kit, but did not recognize it was the wrong dose. When interviewed on 7/28/20, at 2:42 p.m. RN-B stated HIMS-A requested she review the [MEDICATION NAME] order for R1 on 7/24/20, and she had done so and approved it. RN-B acknowledged the dosage calculation for the [MEDICATION NAME] was incorrect, but had not noticed it at the time as, was most likely between tasks at the time. When interviewed on 7/29/20, at 10:45 a.m. the director of nursing (DON) stated the dose of [MEDICATION NAME] in the emergency kit only contained 0.4 mg/ml and only contained 1 ml, therefore RN-B could not have given the correct dose, and RN-B had stated she used a [MEDICATION NAME] syringe, with a very short needle, which means it could not have been given into a muscle as ordered either. The DON stated they had started to re-train nurses on transcribing physician orders [REDACTED]. However, the training did not include drug dosage calculations, which was the root cause of the error. When interviewed on 7/29/20, at 10:21 a.m. the consultant pharmacist (CP)-I stated if the facility needs a medication STAT, they can take the medication from the emergency kit and call the pharmacy to get a delivery at any time of the day or night. The pharmacy is also always available to assist with drug calculations as needed. The [MEDICATION NAME] 0.4 mg/ml is a common dose to be used in nursing homes, if the order was for a higher dose, they would have to order the medication STAT. When interviewed on 7/29/20, at 11:30 a.m. medical director (MD)-A indicated that a normal dose of [MEDICATION NAME] to treat a severe opioid overdose would be [MEDICATION NAME] 2-4 mg IM. MD-A stated that a dose of 80 mg of [MEDICATION NAME], Would reduce respirations and cause sleepiness and lethargy. Theoretically it could end their life. MD-A stated they were in the process of reviewing the dosage of [MEDICATION NAME] available in the facilities emergency kit and increasing it to 2 mg. The nurse should have called EMS for support or to get additional [MEDICATION NAME] if not able to get the correct dose STAT. When interviewed on 7/29/20, at 10:47 a.m. hospice nurse, RN-G stated they had arrived at the facility and noted R1 continued to be unresponsive with a respiratory rate of 8 breathes per minute with a repeating pattern of 4 breathes followed by 15 second periods of apnea. RN-G informed RN-E and RN-F to administer any [MEDICATION NAME] available in the facility. RN-H returned from the facility assisted living section with a bottle of [MEDICATION NAME] 4 mg nasal spray, which was administered and R1 began to respond and apnea ceased. When interviewed on 7/30/20, at 9:27 a.m. RN-E stated they had come into work on 7/25/20, at 7:45 a.m. and found R1 unresponsive with a respiratory rate of 10. Hospice was contacted and stated RN-G would come to the facility to assess R1. RN-E checked the emergency kit and noted there was one 1 ml vial of [MEDICATION NAME] 0.4mg/ml remaining. RN-E discussed with RN-F and called the pharmacy and discovered the pharmacy had never received the order for the [MEDICATION NAME] 2 mg STAT. They would fill it ASAP. RN-E stated they decided to await the arrival of the hospice nurse before determining whether to give more [MEDICATION NAME], even though R1 was unresponsive with apnea. When interviewed on 7/30/20, at 10:12 a.m. RN-F stated, they had assessed R1 on 7/25/20, between 7:00 a.m. and 8:00 a.m. R1 had a respiratory rate of 8-10 per minute, had apnea, and was unresponsive. RN-F stated the pharmacy was contacted to find out where the [MEDICATION NAME] was and found out they had not received the order. The emergency kit only contained 0.4 mg of [MEDICATION NAME]. The correct dose was ordered as STAT and RN-F and FN-E decided to wait until the hospice nurse, RN-G arrived to determine next steps. When interviewed on 7/30/20, at 11:57 p.m. nurse practitioner (NP)-A stated, R1 had become severely hypoxic (low oxygen) following the [MEDICATION NAME] overdose and a possible consequence to this could be death. When interviewed on 7/30/20, at 12:03 p.m. the DON stated, HIMS should not do drug dose calculations, nurses need to double check the work of HIMS with medication transcriptions to ensure accuracy. STAT orders should be processed and ordered from the pharmacy immediately, if the correct dose of [MEDICATION NAME] was not in the e-kit, staff should have contacted the ordering physician, or contacted EMS for support. In the case of an overdose, the nurse could use their critical thinking and use the [MEDICATION NAME] dose that is available even if less than ordered. Nurses should be knowledgeable about how to administer each route of medication. The facility submitted a training entitled Intradermal Injection/Subcutaneous Medication/Intramuscular, and Medication Administration Education, which included medication order processing, which showed facility nurses had been retrained on 7/25/20. However, the training lacked any education notification of physician with condition change, monitoring resident's after medication error, calculation drug dosages, or how to choose the appropriate syringe for injections. The facility Medication Administration Policy dated December 2018, identified accurate transcription of orders is the responsibility of licensed nursing staff. The policy did not indicate other staff who could transcribe medication orders. The policy included, the Medication Administration Record [REDACTED]. The facility Order Processing Policy dated February 2016 indicates that physician medication orders should include time and frequency of the medication and should include the route of administration. The immediate jeopardy that began on 7/24/20, was removed on 7/30/20, when the facility educated all licensed nurses on dosage calculation, correct syringes and techniques for injectable medications, how to verify orders that are input into the EMR by unlicensed staff,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245617	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARONDELET VILLAGE CARE CENTER	**525 FAIRVIEW AVENUE SOUTH SAINT PAUL, MN 55116**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) observation of the resident after a medication error/overdose, notification of physician when there is no access to the correct dose of STAT medications and utilization of the EMS system if needed, ordering STAT medications from the pharmacy, and how to recognize an inappropriate dose of medication. In addition, Mollies staff responsible for inputting orders into the EMR were retrained and educated to consult with a nurse when in doubt of an order. The facility also conducted an audit on all liquid medications to ensure accuracy in the EMR. Audits were started on all new orders, which were to continue for 14 days and be re-evaluated. All nurses and trained medication aides (TMA's) were audited for medication administration. This was verified by observation, interview and document review by the surveyors on 7/30/20. However, the noncompliance remained at the lower scope and severity level of a G, isolated actual harm that is not immediate jeopardy, because R1 was harmed when she received the incorrect doses of [MEDICATION NAME] and became unresponsive with respiratory distress, received the wrong dose of the reversal medication and the unresponsive episodes and respiratory distress continued for over 24 hours.