| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245164 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villas at New Brighton | 825 First Avenue Northwest<br>New Brighton, MN 55112 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on interview and document review, the facility failed to ensure professional standards of practice for medication administration were followed for 1 of 3 residents (R1) reviewed.<br><br>Findings include:<br><br>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of acute embolism and thrombosis of deep vein of left lower extremity and was cognitively intact.<br><br>R1's Order Recap Report dated 12/12/24, indicated R1 had an order for Buprenorphine HCL (an opioid medication used to treat acute pain, and chronic pain) Buccal (Buccal administration involves placing a drug between your gums and cheek, where it also dissolves and is absorbed into your blood) Film 600 micograms (mcg) place and dissolve one film buccally every morning and at bedtime for pain ordered on 10/14/24, and discontinued on 11/6/24. Further, R1 had an order for Buprenorphine HCL sublingual two milligrams (mg) give one mg sublingually in the morning for pain ordered on 11/6/24, and discontinued on 11/21/24.<br><br>R1's Medication Error Reconciliation Form dated 11/14/24, indicated R1 did not receive her Buprenorphine sublingual tablet on 11/9/24, and 11/10/24, and R1 was given the Buprenorphine HCL Buccal Film instead. R1 was stable however, was upset with staff over the error. Further, the form indicated an investigation completed on 12/12/24, revealed the nurse gave R1 the wrong pain medication, R1 had a recent medication change, R1 was aware of her medications and reported the nurse did not listen when she told her it was wrong. R1 did not have adverse effects and provider did not feel monitoring or change of order was necessary. Director of nursing (DON) provided education to the nurse involved. In addition, a statement was obtained from licensed practical nurse (LPN)-B by DON, and LPN-B stated she gave R1 the film because LPN-B could not find the sublingual medication. LPN-B stated she called the pharmacy and they indicated they could not send it that day and they would send it later. LPN-B confirmed she did not call the provider. LPN-B stated after R1 took the medication, R1 then informed LPN-B that was the wrong medication and then LPN-B looked. DON interviewed LPN-C as well who indicated LPN-C checked and found the sublingual tablets. The medication had been delivered a couple days prior to the medication error as they were administered on 11/7/24, and 11/8/24.<br><br>(continued on next page) |



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

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| The Villas at New Brighton | 825 First Avenue Northwest<br>New Brighton, MN 55112 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/12/24 at 11:01 a.m., R1 was laying in her bed in her room. R1 appeared comfortable and there were no pain indicators observed. R1 stated she was aware LPN-B gave her the film form rather that the tablet form for her pain medications. R1 stated she attempted to tell LPN-B however, LPN-B stated the tablets were discontinued and appeared to not believe R1. R1 preferred if LPN-B did not administer her medications anymore as the incident was upsetting to her.<br><br>On 12/12/24 at 2:07 p.m., attempted phone interview with LPN-B was unsuccessful.<br><br>On 12/12/24 at 2:54 p.m., LPN-C stated she was made aware of R1's medication error by social services. LPN-C stated R1 had been receiving Buprenorphine film prior and the order had changed to tablet instead. LPN-C indicated there was a mix up and R1 ended up receiving the film instead. LPN-C confirmed the facility had R1's tablets in the narcotic box and were available for administration at the time of the medication error. LPN-C stated she notified the provider at the time the error was discovered and no new orders where obtained. Further, LPN-C stated staff were expected to be completing the safety checks for the right medication, right dose, right form, and right person prior to administering the medication.<br><br>On 12/12/24 at 3:26 p.m., interim director of nursing (DON) stated the medication error process was started when the medication error was identified on 11/14/24, and the provider was notified. DON indicated the previous DON had not completed the follow up and investigation portion of the medication error which was why that portion was completed on 12/12/24. DON stated the root cause of the medication error was due to LPN-B being unable to find the tablets and thought she could administer the film instead. DON stated she re-educated LPN-B on 12/12/24, regarding following orders and staff were not allowed to administer something different without the provider's permission. Further, DON stated the medication was the same however, was a different route and there was no adverse outcome noted for R1.<br><br>Review of facility policy titled Preparation and General Guidelines dated 4/18, indicated staff were expected to utilize the 5 rights-right resident, right drug, right dose, right route, and right time for each medication being administered.<br><br>Review of facility policy titled Medication Error Procedure dated 1/20, indicated when a medication error occurred, the person responsible for the error or the person finding the error would complete the Medication Error Reconciliation Report. Further, the policy directed staff to contact the provider to inform them of the error by giving a description of the error and documenting provider comments and follow-up. The policy indicated the DON or designee would complete the Investigation Summary and meet with the person making the error and record education or follow-up action. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on interview and document review, the facility failed to ensure a referral was made to an outside agency for psychiatric services as ordered by a physician for 1 of 1 resident (R3) reviewed.<br><br>Findings include:<br><br>R3's quarterly Minimal Data Set (MDS) dated [DATE], indicated R3 had diagnoses of bipolar disorder, protein-calorie malnutrition, and adult failure to thrive.<br><br>R1's physician order dated 11/29/24, indicated ACP (Associated Clinic of Psychology) referral, diagnosis concern for restrictive/avoidant eating.<br><br>On 12/12/24 at 12:20 p.m., licensed practical nurse (LPN)-A confirmed R3 was not currently being seen by ACP and was last seen on 9/25/24. LPN-A was unaware if a referral had been made following the new order and stated social services (SS) submitted the ACP referrals.<br><br>On 12/12/24 at 3:09 p.m., SS-A confirmed he was not aware of R3's order for an ACP referral and typically would be notified by the admissions staff or health coordinators would bring the order to SS-A to complete the referral. SS-A confirmed a referral had not been made.<br><br>On 12/12/24 at 3:26 p.m., interim director of nursing (DON) stated if an order were to be received for an ACP referral, the staff would give the order to SS and to SS was aware and within a week, at least, a referral would need to be made.<br><br>Requested for a policy related to physician orders however, the facility did not have a policy. |