

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/31/2024
NAME OF PROVIDER OR SUPPLIER  Seasons Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  303 Broadway Avenue South Trimont, MN 56176	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49336</p> <p>Based on interview and document review the facility failed to ensure the on-call physician was notified timely of a change in condition, and later the primary care physician during normal business hours of suspicion of unauthorized narcotic medication (Oxycodone) ingestion, and investigate potential suicidal ideation for 1 of 1 resident (R1) and put safety measures immediately into place after ingestion of narcotic pain medication was likely.</p> <p>Findings include:</p> <p>Review of the National Capital Poison Center, Poison Control current guidelines, located at <a href="https://www.poison.org/articles/treating-and-preventing-opioid-overdose-182">https://www.poison.org/articles/treating-and-preventing-opioid-overdose-182</a>, identified signs of an opioid overdose can include the following:</p> <ol style="list-style-type: none"> <li>1) Not waking up or not responding to voice or touch</li> <li>2) Skin is pale, gray, and clammy</li> <li>3) Lips and fingernails turning blue or purple</li> <li>4) Breathing is very slow, irregular, or has stopped</li> <li>5) Slow heartbeat or low blood pressure</li> <li>6) Pinpoint pupils (the center circle of the eye is very small)</li> </ol> <p>It is important to know that not all of these signs will necessarily be present.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245315
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Cleveland Clinic, Opioid Overdose current guidelines, located at, <a href="https://my.clevelandclinic.org/health/diseases/24583-opioid-overdose">https://my.clevelandclinic.org/health/diseases/24583-opioid-overdose</a>, identified an opioid overdose happens when opioids excessively stimulate the part of your brain that regulates breathing. This leads to respiratory depression (ineffective breathing) and can cause death if it isn't treated in time. An opioid overdose can happen when a person takes too much of an opioid or a combination of opioids and other substances, such as alcohol, sedatives or stimulants. Too much varies from person to person depending on their opioid tolerance and the potency (strength) of the opioid they're using. An opioid overdose is a medical emergency. People experiencing an opioid overdose need naloxone (commonly known by the brand name Narcan(R)). Naloxone can reverse the effects of an overdose if it ' s given to the person quickly. The person will still need medical attention after the administration of naloxone.</p> <p>R1's, 10/13/24, 5-day Minimum Data Set (MDS) identified R1 had an admitted October, 2024. with diagnoses of chronic kidney disease,heart attack, and peripheral vascular disease (decreased blood flow to extremities). R1 was cognitively intact and had no behaviors.</p> <p>R1's Medication Administration Record (MAR) identified MD-A was documented as being R1's primary care physician.</p> <p>R1's 10/23/24, progress notes identified at:</p> <p>1) 6:51 a.m., registered nurse (RN)-C wrote and end of shift note. During her shift, R1 had been awake most of the night. He had his eyes open when staff entered his room. R1 was slow to respond, did not speak and only nodded slightly when asked questions. His respiratory rate was noted to be within normal limits at 18 respirations per minute, but his oxygen was slightly lower at 92% (normal is 95% to 100%). R1's arms and hands appeared slightly [NAME]. RN-C noted she found 10 pink pills lying on a Kleenex at his bedside table. She questioned R1 about what they were and where they came from. R1 did not respond verbally and only nodded his head toward the nightstand. She did not see any tablets or bottle in his nightstand and removed the pills she found from his room. There was no mention RN-C identified the potential overdose symptoms and called the on-call after hours provider immediately upon assessing R1 and identifying his abnormalities noted above. It was also not noted when this occurred.</p> <p>2) 11:05 a.m., the director of nursing (DON) noted she and RN-B went to R1's room and discussed the pills that were found in his room. The DON asked R1 if he knew what they were. R1 stated Well I imagine they are oxycodone. R1 denied having any other pills in his room. The DON and RN-B searched R1's room. No other pills were found. The DON and RN-B advised R1 his risk of overdose as he was already prescribed oxycodone for pain. The DON reiterated staff did not want R1 to overdose, however, it was not clear in the note if the DON or RN-B had attempted to find out why R1 took the medication or if MD-A had been notified of R1's condition if not on-call.</p> <p>3) 11: 41 a.m., it was noted a care conference was held, however nursing staff did not enter any note.</p> <p>3) 3:45 p.m., staff noted R1 had multiple episodes of vomiting during the shift. There was no mention the on-call provider was notified of the changes in R1's health.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/29/24 at 10:56 a.m., with R1 identified he had brought in a bottle of 10 milligram (mg) oxycodone pills from home and could not remember how many pills were in the bottle before bringing it into the nursing home. He had taken 7 pills at one time, stating he used them to attempt to kill himself. The pills made him sick and had experience vomiting during the day. He attempted to transfer himself to the bathroom in the morning after ingesting the pills, when the urge to vomit came over him and he had fallen on the floor near the bathroom. He vomited on the floor and the staff had cleaned him up and assisted him back to bed. Staff found his oxycodone pills on his bed and collected the medications and asked if he had any more medications, to which he stated, no. He did not inform staff that he wanted to kill himself and would not talk about it with staff until I am ready. R1 had no current desire to kill himself.</p> <p>R1's 10/24/24, progress notes identified at:</p> <p>1) 7:07 a.m., R1 was found sitting on the floor in front of his wheelchair. R1 stated he got up from his bed and slipped trying to get dressed. R1 stated he forgot to use his call light.</p> <p>2) 8:22 a.m., RN-B noted she spoke with R1's family member about the pills discovered the previous day. R1 was reported to call the family member on 10/23/24, around 7:30 p.m., stating he had been self transferring that day and almost slipped in the bathroom. The family member noted R1 must have gotten the pills from home on 10/23/24. Staff reported to the family member they also found a nicotine vape pen and a pocket knife in his possession. RN-B noted on 10/23/24, R1 was receiving cares. A nursing assistant noted R1 was swallowing his mouth wash. RN-B noted R1 will be placed on 30 minute safety checks and will suggest a detox/rehab facility to better assist resident for possible withdrawals. It is unknown why R1 was not placed on any safety checks after suspicion of oxycodone overdose had occurred, or if an investigation had been done to identify R1's potential of suicidal ideation when it was discovered R1 also had a knife in his room. It is also unclear if staff notified R1's provider of a knife.</p> <p>R1's documented Safety Checks identified they began on 10/24/24 at 8:30 a.m There was no indication staff had identified the need for safety checks put into place immediately at the time after the oxycodone and/or knife was found.</p> <p>Review of R1's 10/25/24, progress notes identified at:</p> <p>1) 9:19 a.m., R1 was noted to be confused that day. He was found by staff packing his room and thought he was going home with family due to insurance coverage. R1's lab results were noted to be abnormal. The nurse practitioner (NP) was seeing R1 that day.</p> <p>2) 11:38 a.m., R1 was noted to be only alert and oriented (A/O) x 1 (normal is 3- person, place, or time).</p> <p>3) 7:18 p.m., staff noted the NP signed telephone orders for grab bars, monitor R1's respirations, and push fluids due to emesis [vomiting] after possible OD [overdose] oxy [oxycodone]. Staff were to check vitals every 2 hrs and throughout the night. The NP was noted to sign a paper accepting him as her patient. It is unknown if R1's primary physician MD-A had been notified of R1's oxycodone ingestion and/or symptoms of potential overdose.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/29/24 at 12:42 p.m., with family member (FM)-A identified R1 have voiced concerns about killing himself before he was admitted to the nursing home. She had visited R1 on one or more occasions and he would say to her that he did not want to live and had voiced wanting to die while he was at the nursing home. FM-A did not share the information to the nursing staff at the facility.</p> <p>Interview on 10/30/24 at 8:01 a.m., with nurse practitioner (NP)-A identified she was aware R1 had a fall and was informed R1 had oxycodone pills in his room, however she could not recall staff informing her of their assessment identifying R1 as having ingested the pills. She was not aware that R1 wanted to kill himself and stated she had visited R1 on 10/25/24 at the facility. R1 did not voice concerns of wanting to kill himself to NP-A. She would expect the facility to follow their policy and protocols related to notification to the provider for a resident change of condition and ensure staff gave all information so the need for further medical assessment if warranted, could be determined.</p> <p>Interview on 10/30/24 at 10:12 a.m., with the director of nursing (DON) identified she was informed R1 pills were confiscated and locked up. The on-call provider was contacted of R1's oxycodone being found, and stated the facility did not receive orders to send the R1 to the ER. She was informed by RN-C that R1 had fallen and was not aware that R1 had talked of suicide contemplation. In addition, she was not aware if RN-C had accurately assessed the reason for R1 taking the oxycodone tablets when found and would expect R1 be sent to the ER (emergency room ) for further medical evaluation when oxycodone was found in his room on 10/23/24, to identify if ingestion had occurred.</p> <p>Interview on 10/30/24 at 10:39 a.m., with the administrator had identified the facility nursing department needed improvement and confirmed R1's situation was not an acceptable nursing practice.</p> <p>Interview on 10/30/24 at 11:08 a.m., with registered nurse (RN)-A stated the situation occurred sometime during the overnight shift on 10/23/24 with R1's oxycodone being found in his room. Upon becoming aware from the off-going nurse, she contacted the on-call provider, who then informed her to monitor R1 for changes in his condition. During her conversation with R1, she had assessed him and determined R1 appeared normal to her. R1 had mentioned to her that he had taken some oxycodone but did not know when or how many he had took. She was unable to recall if she reported R1 had advised her he ingested it to the on-call provider. She did not receive an order from the provider to transfer R 1 to the ER for evaluation as was facility policy to get an order to send a resident to the ER vs using nursing judgment based off best practice. Nurses were to contact the on-call and/or primary provider before sending any resident out to the ER for medical evaluation and facility policy directed staff were required to get an order of transfer from the provider. She agreed R1 should have been transferred to the ER for further medical evaluation of ingestion of oxycodone and during her assessment, and try and identify the cause behind the ingestion and ensure safety measures were placed.</p> <p>Interview on 10/30/24 at 11:45 a.m., with RN-B identified R1's behavior to her appeared strange on 10/23/24. She could not identify the reason. She was aware R1 would visit his sister outside of the facility during the day and appeared to look weak and had slowed speech when he arrived back to the facility on [DATE]. She had received on shift report from RN-C that R1 had pills found in his room. At that time, RN-B and RN-C then used the online Google search engine to look up the pills and verified they were oxycodone. She had informed the administrator and DON of R1's pills approximately at 7:30 a.m., on 10/23/24. In addition, R1 had 4 episodes of vomiting, and she had called on-call provider for assistance and had received orders to manage R1's withdrawal symptoms. She had contacted the nurse practitioner and had not received an order to transfer R1 to the ER.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/30/24 at 12:26 p.m., with the medical director stated the facility had informed her pills were found in R1's room and the facility had received orders to monitor for R1 withdrawals. If R1 had taken pills (narcotics) and had found out that R1 had used them to attempt suicide, she would expect nurses to send R1 to the ER for emergent evaluation and the appropriate physician's be notified.</p> <p>Interview on 10/31/24 at 1:58 p.m., with RN-A identified she arrived at the facility between 7:45 a.m. and 8:00 a.m., on 10/23/24. She was approached by RN-B who appeared shocked and had informed her during shift change that RN-C had discovered R1 had pills in his room and they were now locked in the medication room. She had observed R1 in the dining room during breakfast that morning and had assessed his interaction with other residents. She had no concerns of his behavior or mood during breakfast. She did not call the overnight nurse to gather additional information of R1's pills and had relied on the progress note RN-C had put into Point Click Care (PCC), (medical record system). She called the on-call contact number and was transferred to an available on-call provider approximately at 9:30 a.m. The on-call provider had given orders to search R1's room and provide education. She had the conversation with R1 approximately at 11 a.m., with RN-B as her witness in his room. R1 had admitted to her that the pills were oxycodone and agreed to have her and RN-B search his room. She confirmed they did not find a pill bottle or other pills in R1's room after the search.</p> <p>Interview on 10/31/24 at 3:41 p.m. with RN-C stated she had worked the overnight shift on 10/22/24 along with an agency nursing assistant who had informed her she had seen pills on R1's dresser. On 10/23/24 at approximately 1:00 a.m., RN-C had entered R1's room and found 10 small pink pills on his dresser. She had question R1 of the pills and did not receive a response from him. R1 appeared to look at her and had not speak but had nodded his head she had questioned R1. She informed R1 she would take his pills and had stored them in the medication room. She stated she had checked on R1 during her shift and had initiated a progress note, approximately after 6:00 a.m. She did not contact the on-call provider, administrator, or the DON of R1's pills and should have. She had informed RN-B during shift change later that morning and had left the facility. She did not investigate the reason R1 took the pills, or assessed R1 for safety.</p> <p>Interview on 10/31/24 at 4:09 p.m. with administrator agreed the nursing staff should have notified the provider, immediately when narcotics were discovered in R1's room.</p> <p>Review of 8/12/22 Change of condition policy identified in the event of an acute condition that would require immediate attention, the charge nurse was to contact the resident representative and primary physician and/or acting physician for direction. The resident was to be sent to the hospital of choice based on the physician's order and resident choice. There is no indication in the policy the facility advises staff of preventative measures to put into place if an incident like an overdose is suspected, what safety measures staff needed to put into place, or that staff can follow standards of practice and identify an emergent or potentially emergent situation and send a resident for medical evaluation to the ED.</p> <p>Review of 3/28/22 Physician Care in Emergency policy identified the charge nurse would notify emergency medical services (EMS) and have the resident transferred to the emergency room for immediate care as deemed necessary.</p>		