STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 West 31st Street Minneapolis, MN 55408

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47264 Based on interview and document review, the facility failed to ensure one of three residents (R2) reviewed was free from significant medication errors. This resulted in actual harm for R2 when he became heavily sedated by a psychotropic medication and required treatment in the hospital. Findings include: Minimum Data Set (MDS) admission assessment dated [DATE] indicated R1 admitted to the facility on [DATE]. R1's Brief Interview for Mental Status (BIMS) had a score of 15, indicating she was cognitively intact. R1's relevant diagnoses included schizoid personality disorder, borderline intellectual functioning, and unspecified urinary incontinence. R1's medication order, dated 6/9/22, indicated R1 received clozapine 600 milligrams (mg) by mouth at 8:00 p. m. nightly for schizophrenia. R1's medication order, dated 6/9/22, indicated R1 received desmopressin acetate 0.2 mg by mouth at 8:00 p. m. nightly for urinary incontinence. R2's MDS admission assessment, dated 2/5/24, indicated R2 admitted to the facility on [DATE]. R2's BIMS had a score of 15, indicating he was cognitively intact. R2's relevant diagnoses included schizoid personality disorder, diabetes mellitus type II, chronic kidney disease stage 5, hyperlipidemia, and hypertension. R2's medication order, dated 1/29/20, indicated R2 received quetiapine fumarate 50 mg by mouth at 8:00 p. m. nightly for schizoid personality disorder. R2's medication order, dated 1/30/24, indicated R2 received atorvastatin calcium 80 mg by mouth at 8:00 p. m. nightly for hyperlipidemia. R2's medication order, dated 1/30/24, indicated R2 received carvedilol 25 mg by mouth twice per day, at 8:00 a.m. and 8:00 p.m., for hypertension. R2's medication order, dated 3/16/24, indicated R1 received olanzapine 5 mg by mouth twice per day, 8:00 a. m. and 8:00 p.m., for schizophrenia. (continued on next page)

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

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NAME OF PROVIDER OR SUPPLIER Birchwood Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 715 West 31st Street Minneapolis, MN 55408	

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R2's care plan, dated 2/9/24, indicated a nursing intervention was to administer all medications as ordered. A nursing note written dated 6/30/24 at 11:42 p.m., indicated on 6/30/24 at approximately 9:30 p.m., R2 received R1's scheduled medications. The note indicated the provider and the provider's clinic nurse were notified and gave instructions to administer R2's scheduled atorvastatin 80 mg and carvedilol 25 mg, and to hold the quetiapine fumarate 50 mg. R2 was conversational at the time and took the medications without issue. Nursing aide (NAR)-A was leaving the facility at approximately 10:40 p.m. when they discovered R2 heavily sedated, but able to respond to verbal stimuli. Staff moved R2 to the floor and called emergency medical services (EMS). R2 was transported by EMS to a local hospital, and R2's family, the director of nursing (DON), nurse manager, and social services director were notified. A Medication Error Report indicated registered nurse (RN)-A gave R2 R1's medication cup at 9:30 p.m. The report indicated R1 and R2's medications had been sitting in plastic cups near each other, and RN-A picked up the wrong cup and gave it to R2. R2 experienced increased sedation because of the medication error and was transported to the hospital for treatment. A hospital note dated 7/1/24 at 6:40 p.m. indicated R2 was seen in the emergency room following the unintentional administration of clozapine 600 mg, desmopressin 0.2 mg, and olanzapine 5 mg. The note indicated he was admitted to the hospital from the emergency department to the observation unit on 7/1/24 at 12:24 p.m., and then transferred to the intensive care unit (ICU) at 4:40 p.m. R2 was experiencing acute toxic metabolic encephalopathy and acute hypoxemic respiratory failure related to the high dose of clozapine he received. R2 was intubated and sedated for airway protection at an unknown time. On 7/3/24 at 9:06 a.m., an observation of a medication pass revealed no medication administration errors were made. During an interview on 7/3/24 at 9:23 a.m., trained medication assistant (TMA) -A stated prior to administering medication she verifies the identity of the resident. TMA-A stated she verifies the correct resident, the medication, the dose of the medication, the time the medication is to be administered, and the route of administration. TMA-A stated she only administers one resident's medications at a time to avoid making any errors. During an interview on 7/3/24 at 9:57 a.m., RN-B stated he verifies residents by the first and last name. RN-B stated if two residents have the same name, he will use their date of birth as an identifying factor as well. RN-B stated if a resident does not know their date of birth or are unable to answer, he used the room number of the resident to verify their identity. RN-B stated he verifies the five rights of medication administration prior to administering any medication. RN-B stated he only administers one resident's medication at a time. During an interview on 7/3/24 at 10:37 a.m., NAR-A stated she was leaving the facility on 6/30/24 at approximately 10:40 p.m. when she walked by R2, who was seated in the common area. TMA-A stated she said goodnight to R2, who did not respond. TMA-A tried to speak with R2, he was unable to respond. TMA-A stated she ran and told RN-A and together they moved R2 to the floor. TMA-A stated she held R2 while RN-A called for EMS. TMA-A stated she knew there had been a medication error with R2 earlier that evening, but R2 was not exhibiting any abnormal symptoms prior to 10:40 p.m. (continued on next page)

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F 0760

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 7/3/24 at 11:39 p.m., the nurse manager stated all staff who worked since the incident was discovered have been retrained on how to administer medications. The nurse manager stated all nursing staff must verify the five rights of medication administration - right patient, route, medication, dose, and time - prior to administering medications. The nurse manager stated a patient's medications should be prepared individually and no medications can be preset prior to administering. The nurse manager stated presetting medications in batches is not a practice at their facility. The nurse manager stated she completed the educational training for herself under the direction of the clinical compliance nurse.

During an interview on 7/3/24 at 12:04 p.m., RN-C stated prior to administering medications, you must verify the five rights of medication administration. RN-C stated any medication errors must be reported immediately to the DON, the provider, the resident, and the resident's family.

During an interview on 7/3/24 at 12:15 p.m., the clinical compliance nurse stated she observes nursing staff preparing individual medications. The clinical compliance nurse stated when she watches her staff, she is making sure they are working on medications individually and are verifying the five rights of medication administration. The clinical compliance nurse stated overnight nursing staff are being tested out by the nursing manager or charge nurse prior to working.

During an interview at 12:45 p.m., the nurse manager stated the hospital informed them R2 will be returning to the facility later today directly from the ICU without any changes in baseline functioning or medication changes.

During an interview on 7/3/24 at 1:40 p.m., the direct of social services stated RN-C texted her on 7/1/24 at approximately 1:30 a.m. regarding the medication error. The direct or social services stated on the morning of 7/1/24, she contacted the administrator immediately and determined it was a reportable event.

During an interview on 7/3/24 at 1:45 p.m., the DON stated she received a text from RN-A on 6/30/24 at approximately 12:00 a.m. regarding the medication error and subsequent hospitalization . The DON stated she attempted to interview RN-A multiple times about the incident, however, she has not received any calls back. The DON stated due to RN-A not reporting the medication error to administration immediately and RN-A not complying with their internal investigation, it was decided to terminate RN-A's employment. The DON stated this was RN-A's first medication error. The DON stated the DON from their sister facility had designed the reeducation materials as she was on vacation.

During an interview on 7/3/24 at 1:59 p.m., the DON of the sister facility stated he immediately implemented a reeducation competency and began training staff on 7/1/24. The sister facility's DON stated all staff who administer medication will have to complete reeducation prior to working in the facility and cannot work until it is complete. The sister facility's DON stated he and the clinical compliance nurse watch staff administer medications and ensure they are verifying the five rights with each resident.

RN-A could not be reached for an interview.

A facility document, titled TMA Orientation to Medication Administration, indicated nursing staff must verify the five rights (right resident, drug, dose, time, and route). This form was completed for all nursing staff who worked following the medication error on 6/30/24.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A policy titled Medication Administration Policy, indicated medication will be set up for each resident individually immediately prior to administration.