STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Village	923 Hale Lake Pointe Grand Rapids, MN 55744

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to ensure 1 of 3 residents (R1) reviewed for medication errors received physician ordered medications. In addition, the facility failed to notify the physician of the missed medications. Findings include: R1's Admission Record indicated she admitted to the facility on [DATE]. Diagnosis included atrial fibrillation, chronic kidney disease and hypertension. R1's care plan dated 7/9/24, identified an alteration in health status and directed staff administer medications per physicians order. R1's Order Summary Report printed 7/31/24, identified the following order dated 7/9/24: Slow Magnesium/Calcium oral tablet delayed release 70-117 milligram, give two tablets one time a day for hypomagnesemia. R1's Medication Administration Record for July 2024, indicated she received the medicaion on 7/10/24, 7/15/24 and 7/29/24. All other days staff indicated she did not receive the medication. R1's Hospitalist Discharge Summary dated 7/28/24, indicated she admitted to the hospital on 7/24/24 and discharged on [DATE]. Discharge diagnosis included atrial fibrillation with ventricular response. The discharge summary indicated during R1's hospital stay she required ongoing magnesium replacement. During interview on 7/31/24 at 10:33 a.m., licensed practical nurse (LPN)-A stated if a medication was not available they could either call the pharmacy or fill out a reorder form and send via fax. LPN-A stated usually she just notified the charge nurse. During interview on 7/31/24 at 10:10 p.m., registered nurse (RN)-A, nurse manager, stated when a medication was not available the nurses were supposed to notify her so she could call the pharmacy. RN-A stated she had not been aware R1's magnesium had never been delivered to the facility. During interview on 7/31/24 at 11:59 p.m., nurse practioner (NP)-A stated she had written the order for the Slow Magnesium because when she last saw R1, her magnesium levels were low which could cause an electrolyte imbalance. NP-A stated the facility had not notified her that R1 never received the prescribed medication. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/31/24 at 1:01 p.m. pharmacy technician (PT)-A stated the pharmacy had never delivered R1's magnesium to the facility. PT-A stated the medication was back ordered from their supplier. PT-A stated typically the pharmacy would have either called or sent a fax to the facility to let them know when a medication could not be delivered. During interview on 7/31/24 at 2:05 p.m. the director of nursing (DON) stated she had not been aware R1 had never received her prescribed magnesium and said staff should have notified the physician. Facility Medication Error Management Policy dated 3/31/23, identified medication errors to include medication not available for administration. The policy indicated all medication errors must be reported immediately to the nursing supervisor and DON. The policy further indicated the residents physician or NP must be notified.