STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Living Meadows at Luther - Madelia	503 Benzel Avenue SW Madelia, MN 56062

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(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 to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on interview, and document review, the facility failed to ensure hydromorphone (opioid medication used to treat moderate to severe pain) was administered as prescribed for 1 of 1 resident (R7) reviewed for medication error. This deficient practice resulted in an immediate jeopardy (IJ) for R7 who received a hydromorphone (narcotic opioid) dose ten times greater than what was prescribed and required Narcan (used for the emergency treatment of known or suspected opioid overdose) administration. The IJ began on 4/16/24, at approximately 9:00 a.m. when R7 was administered hydromorphone which was ten times greater than what was prescribed. R7 had to very little to no responsiveness, eyes glossy, respiratory rate 10 breaths per minute (normal 12-20 per minute), oxygen saturations varied and dropped to 87% (normal 95% or greater) on room air. The administrator, director of nursing (DON), and registered nurse (RN)-A, consultant, were notified of IJ on 4/25/24 at 9:35 a.m. The facility had implemented corrective actions on 4/17/24, therefore the deficient practice was issued as past noncompliance. Findings include: R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated R7 was cognitively intact, required moderate staff assistance for activities of daily living. Diagnoses included heart failure, renal failure (kidney failure), polymyalgia rheumatica (inflammatory disease which results in muscle ache and stiffness in different parts of the body), and palliative care, on a scheduled pain medication regimen, received PRN (as needed) pain medications, frequent pain, moderate pain intensity, had a condition or chronic disease that may result in a life expectancy of less than 6 months, taking an opioid medication, and hospice care. A facility reported incident to the state agency (SA) dated submitted on 4/16/24 at 1:03 p.m., indicated on 4/16/24 at 9:00 a.m., R7 was given PRN Dilaudid (hydromorphone) for pain/discomfort by licensed practical nurse (LPN)-A. Nurse (LPN-A) reported she gave 2.5 ml's (milliliters) instead of the prescribed 0.25 ml's (2.5 mg) (milligrams). R7 was given Narcan to reverse the noted adverse effect. The report further indicated R7's RR (respiratory rate) decreased to 11, became glossy eyed, staring off and unresponsive after receiving incorrect dose of Dilaudid. The report indicated nurse (LPN-A) will have a medication pass audit completed today 4/16/24, to ensure she is competent in med pass including medication rights. (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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's medication administration record (MAR) dated 4/1/24-4/30/24, indicated R7 on 4/16/24 had hydromorphone 10 MG/ML liquid dose ordered: (0.25 ml) by mouth every 2 hours as needed for: pain or dyspnea. R7's Individual Narcotic Record dated 4/16/24 at 9:00 a.m., indicated LPN-A documented 0.25 ml of hydromorphone 10 mg/ml was removed. The Individual Narcotic Record dated 4/16/24 at 6:00 a.m., indicated 22.25 ml of hydromorphone remained and the next dose of hydromorphone was removed on 4/16/24 at 9:00 a.m., and 19.75 ml remained. The Individual Narcotic Record indicated 2.5 ml's of the hydromorphone was removed at 9:00 a.m. and had not received the 0.25 ml as the order identified, but instead received 2. 5ml (10 times more than prescribed). Medication Incident Report dated 4/16/24, indicated R7 received 2.5 mg of hydromorphone rather than 0.25 mg. LPN-A written documentation indicated Dilaudid order was 0.25 ml (2.5 mg) by mouth four times a day, drew up in 3 ml syringe, that was in med drawer, went to room administered oral meds first than liquid medications, FM-A and FM-B were in room. Hospice RN-B entered the room as finishing giving medication. RN-A came and wanted to know of any refills for hospice residents, and when checking at about 9:35 a.m. they discovered wrong dose given. RN-B informed both family member (FM)-A, FM-B vitals were obtained eyes fixed, very little to no responsiveness, eyes glossy. RN-B notified NP-C of the incident and NP-C ordered Narcan. The report further indicated Narcan was administered at 10:13 left nostril and 10:16 right nostril. R7 then started responding, talking to staff, eyes no longer glossy, taking sips of water, and talking with family member (FM)-A, FM-B, and RN-B. The incident report further indicated this error could have been prevented for the future: triple check completed and also only 1 ml syringes in cart most of all double check dose/med with another nurse. Adverse outcomes, glossy fixed eyes unresponsive, decreased respirations. N (skilled nursing) daily visit note dated 4/16/24, hospice RN-B indicated findings/plan of care changes R7 was in bed with FM-A at bedside and FM-B joined visit shortly after writer arrived. R7 was very soft spoken and responses delayed. R7 appeared more withdrawn during visit, confusion noted with conversation. R7 had more of a glossy stare today as well, pain 0/10. Med error found at approximately 9:50 a.m., when writer and LPN-A reviewed medication use and needed refills, it was found that 25 mg of hydromorphone was administered instead of the orders dose of 2.5 mg. At 9:53 a.m., telephone call to nurse practitioner (NP)-C to report medication error, and writer spoke to FM-A and FM-B regarding use of Narcan and family agreed with use. NP-C ordered Narcan, and Narcan was used from the facility E-Kit (emergency kit) medication box. Prior to the administration of Narcan, R7 was obtunded, not responding to writer, lips were cyanotic (bluish discoloration of the skin), and respiratory rate was 10/min (breaths per minute), oxygen saturations varied and dropped to 87% on room air, and placed supplemental oxygen at 2L/min. First Narcan administered and 10:13 a.m., and second dose administered into right nostril at 10:16 a.m., R7 remained lethargic and respirations 10/min after the first administration of Narcan. After second dose [Narcan], R7 was alert and very talkative. Writer also called the poison control hotline to report incident and to receive further guidance for symptoms to monitor due to the ingestion of high medication volume, and was indicated to monitor for respiratory depression. 12:50 p.m.-2:22 p.m., RN-B was with R7 to monitor symptoms and towards the end of visit R7's eyes were fluttering and she appeared tired, respirations were regular and even at 18 breaths per minute. NP-C ordered Narcan for use if respiratory repression were to redevelop and increased lorazepam to 0.5 mg every two hours. Writer reviewed with LPN on the evening shift to monitor R7 closely for respiratory depression, educated on use of the PRN Narcan if needed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/24 at 8:15 a.m., FM-A stated herself and FM-B were in R7's room when LPN-A was observed to administer R7 her regular pain medications via a syringe in her mouth. FM-A stated R7 became really out of it after the medication administration. FM-A stated the hospice RN-B was at the facility to assess R7. FM-A stated after RN-B assessed R7, LPN-A entered the room and confirmed she gave the wrong dose of R7's pain med and gave 2.5 ml instead of 0.25 ml. FM-A stated RN-B educated family about that administration of Narcan would reverse of the effects of the high dose of the pain mediation R7 was experiencing. FM-A confirmed R7 was less alert and had decreased breathing. FM-A stated two doses of Narcan was administered nasally to R7. FM-A stated after the first dose of Narcan there was no change in R7, and then after the second dose of Narcan R7 was more alert. On 4/23/24 at 3:18 p.m. LPN-A stated prior to 4/16/24, she had not administered R7's 10 mg/1 ml of Dilaudid. LPN-A stated on 4/16/24 at approximately 9:00 a.m., she reviewed R7's Dilaudid order on the computer and label on the bottle. LPN-A stated she used the 3 ml syringe that was in the bag in the medication cart with R7's name. LPN-A confirmed she drew up 2.5 ml of hydromorphone and R7's other oral meds were crushed and mixed with pudding. LPN-B stated she entered R7's room and FM-A and FM-B were present in R7's room, and she administered R7's crushed oral pills in pudding first with water, and then administered the Dilaudid via syringe in R7's mouth. LPN-A stated the hospice RN-B entered the room during the medication administration. LPN-A confirmed she had given R7 one dose hydromorphone of 2.5 ml (25 mg), and she was unaware she made an error until 9:35 a.m., (35 minutes later) when when hospice registered nurse and LPN-A reviewed R7's medication supply and refills. LPN-A stated both her an RN-B assessed R7 and noticed eyes fixed, very little to no responsiveness, eyes glossy, respiratory rate 10 breaths per minute, oxygen saturations varied and dropped to 87% on room air. LPN-A stated RN-B contacted the hospice provider for direction and NP-C ordered Narcan. LPN-A stated she administered Narcan to R7 into each nostril three minutes apart. LPN-A stated R7 remained lethargic with respirations 10/minute after the first dose of Narcan. LPN-A stated after the second dose R7 became more alert and awake. LPN-A confirmed she read the label on the Dilaudid medication bottle incorrectly and mixed, milliliters versus milligrams and confirmed she was to have administered 0.25 ml versus the 2.5 mg. LPN -A stated after the incident the 3 ml syringes were removed from the medication cart and she will double check controlled substance medications with another nurse prior to administration of resident's medications. LPN-A confirmed she received extensive education from the DON about medication administration and the DON observed and audited her during an administration of mediations. On 4/23/24 at 3:45 p.m., the DON stated on 4/16/24 she arrived at the facility at approximately 11:00 a.m., and LPN-A informed her of the medication error with R7. The DON sated LPN-A confirmed she gave R7 2.5 ml of Dilaudid instead 0.25 ml's. The DON stated Narcan had been given to R7 to reverse the medication error and confirmed the medication error was a serious mistake. The DON stated following the medication error an investigation was immediately started, LPN-A was provided education, additional medication training and competency training. The DON stated education was completed for all nurses and trained medication aides (TMA's) on 4/17/24, on the ten rights of medication administration (right medication, dose, time, route, patient, education, documentation, right to refuse, assessment, and evaluation), education of administering mediation, adverse consequences, medication errors, and controlled substances policies. The DON confirmed a significant medication error occurred and she expected nurses and TMA's to follow give medications as ordered and ensure the label was read and the correct dose was administered to prevent any adverse effects. The DON stated the 3 ml syringe was not expected in the medication cart or used for medication administration. The DON stated the 3 ml syringes were removed and replaced with 1 ml syringes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/24/24 at 4:50 p.m., during a telephone interview the facility consultant pharmacist stated R7's dose of 2.5 mg of hydromorphone was ten times the ordered dose, and could cause adverse effects such as, unresponsiveness, slowed breathing and possible death. The consultant pharmacist stated Narcan would reverse the effects of an overdose of the medication, and stated a smaller caliber syringe for medication administration would be expected when administering a concentrated dose of hydromorphone. The facility consultant pharmacist stated the nurse was expected to read the label and prepare the medication correctly. The facility consultant pharmacist stated the facility to follow physician orders and confirmed a significant medication error had occurred when R7 received 10 times the dose of hydromorphone. On 4/24/24 at 5:44 p.m., during a telephone interview NP-C stated on 4/16/24 at approximate 9:50 a.m., hospice RN-B notified her via telephone R7 had received the wrong dose of hydromorphone. RN-B described that R7 was more sleepy, glossy eyes, was still breathing, and due to observations described NP-C stated she ordered Narcan after talking to the family. NP-C stated any dose of the hydromorphone could cause decreased respirations, and stated the 2.5 ml that was administered was not the correct dose ordered. NP-C stated she was told R7 was more alert after the Narcan administration. NP-C. stated she doesn't know what would have happened if Narcan was not given, and can not speculate the outcome. On 4/25/24 at 9:47 a.m., during a telephone interview RN-B stated on 4/16/24 at approximately 9:00 a.m., she entered R7's room and LPN-A was administering R7's medications and FM-A was at bedside and FM-B entered shortly after. RN-B stated LPN-A and herself reviewed the bound narcotic log book and discussed med refills. RN-B stated when the the log book was reviewed LPN-A knew she administered too much hydromorphone. She assessed R7 who was obtunded, not responding, respirations 10/min and oxygen was at 87%. RN-B explained she then spoke to hospice NP-C and reported the med error, possible use of Narcan, and NP-C gave a verbal order to administer the Narcan. At 9:26 am., R7's respirations were 15 breaths per minutes, and between 9:53 a.m.-10:13 a.m., their respirations were 10 breaths per minute, less arousal and less awake. LPN-A administered the first dose of Narcan and R7 had continued decreased respirations and unresponsiveness, then waited 3 minutes and administered second dose of the Narcan and R7 became more alert and talkative. RN-B stated she contacted poison control and was advised to watch for respiratory depression and continue to monitor the resident. RN-B stated the label on the hydromorphone bottle was correct with 10 mg/ml and to give 0.25 ml. R7's initial hydromorphone was supplied from the local pharmacy and the concentration was 1 mg/1 ml. RN-B stated the hydromorphone R7 received after was supplied by hospice and at a higher concentration. RN-B stated she gave education to staff when a higher concentration was supplied, and a sticker was attached to the bottle and indicated higher concentration. RN-B stated at a previous visit to the facility RN-C confirmed R7 was not using 1 mg/1 ml and she educated RN-C on the 10 mg/ml with the 0.25 ml dosing. RN-B stated she would expect staff to use the 1 ml syringe that comes with the medication. RN-B confirmed the facility took action right away and removed the 3 ml syringe from the medication cart and replaced with 1 ml syringe. The facility Administering Medications policy dated 4/19, indicated: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration; e. any complaints or symptoms for which the drug was administered; 29. New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. The facility Adverse Consequences and Medication Errors policy dated 2/23, indicated: 1. An adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: adverse drug/medication reaction; side effect 2. The staff and practitioner strive to minimize adverse consequences by: following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; 3. Residents receiving medication are monitored for adverse consequences. 4. Adverse consequences are promptly identified and reported. Medication Errors (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: wrong dose, requiring treatment with a prescription medication. resulting in cognitive deterioration or impairment, life threatening, resulting in death. 4. Medication errors are managed according to facility policy. Procedures 1. Review the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. 2. When a resident receives a new medication order, review the following: The dose, route of administration, duration, and monitoring are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use. 3. Evaluate the resident for possible medication-related adverse consequences when the resident has clinically significant change in condition/status, including: 4. Monitor the resident for medication-related adverse consequences w 5. In the event of a significant medication-related error or adverse consequence, take action, as necessary, to protect the resident's safety and welfare. 6. Promptly notify the provider of any significant error or adverse consequence. 7. Implemented the provider orders and monitor the resident for 24 to 72 hours, or as directed. 8. Communicate the event to the oncoming shift as needed to alert staff of the need for continued monitoring. 9. Document the following information in an incident report and in the resident's clinical record: 11. Data regarding medication adverse consequences and errors The past noncompliance IJ which began on 4/16/24, was removed as of 4/17/24, when the facility implemented corrective action which was verified through observation, interview, and document review. The plan included: -All nurses/TMA's on 4/17/24, educated on and given copy of Administering Medication, adverse consequences and medication errors, and controlled substance policies as well as educated and given a copy of the Rights of Medication Administration. -Removal of the 3 ml syringe from all medication carts and replaced with 1 ml syringe, staff education on use of the 1 ml syringe only in the medication carts (continued on next page)

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