STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Minneapolis	5101 Minnehaha Avenue South Minneapolis, MN 55417

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 - 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** 44649 Based on interview and record review, the facility failed to ensure that a resident was free from a significant medication error for 1 of 3 residents (R1) reviewed for medication errors. This resulted in an Immediate Jeopardy (IJ) citation when licensed practical nurse, (LPN)-A administered morphine, a narcotic medication, 20 times the amount that was ordered by the provider. The immediate jeopardy began on 4/11/25 p.m. when LPN-A administered 20 times the amount of liquid morphine to R1 and was identified on 4/17/25. The director or nursing (DON) and the Administrator were notified of the immediate jeopardy at 3:03 p.m. on 4/17/25. The immediate jeopardy was removed on 4/17/25, and the deficient practice corrected on 4/14/25, prior to the start of the survey and was therefore was issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1's primary diagnosis was cerebral vascular accident (stroke). Other diagnoses included: diabetes, dementia and atrial fibrillation. R1's Brief Inventory of Mental Status (BIMs) assessment was not conducted as R1 was rarely/never understood. R1 was dependent upon staff for toileting and personal hygiene, dressing, transferring and rolling from side to side in bed. MDH has the MDS printed from ASPEN. R1's progress note dated 4/11/25 at 11:00 p.m. indicated R1's blood pressure (BP) was 158/61, (normal 100/60 - 120/80), pulse (P) was 73 normal (60-100) oxygen saturation (SpO2) was 86% to 91% (normal 90% - 100%). Oxygen levels were fluctuating, the nurse practitioner (NP) was called. The NP advised 2-4 liters (L)of oxygen. If oxygen levels did not improve R1 was to be sent to the hospital. R1's oxygen remained below 88% and his family declined hospitalization . The NP ordered 5 milligrams (mg) of Morphine every hour as needed. R1's order dated 4/11/25 indicated R1 was to take morphine 5 mg (20 mg/1 ml) oral every hour as needed for shortness of breath. R1's individual narcotic record dated 4/11/25, indicated morphine 20 mg/1 ml. Give 5 mg every hour as needed. The quantity of liquid morphine prior to administration was 15 ml and after administration at 11:45 p. m. was 10 ml, indicating R1 received 5 ml (add 100 mg) and not 5 mg as ordered. (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	R1's progress note dated 4/12/25 at 1:49 a.m., indicated a medication error morphine 5 ml given instead of ordered dose of morphine 5 mg. The NP was notified. R1's BP was 160/74, P 74, R 26, and SpO2 93% on 2 L NC. NP advised to hold the morphine for the next few hours and monitor R1. R1's progress note dated 4/12/25 at 3:00 a.m., indicated death at 2:50 a.m. R1 was unresponsive, and vitals had ceased at 2:50 a.m., pupils were fixed, and no pulse was found. Upon interview on 4/17/25 at 10:20 a.m., registered nurse (RN)-A stated the nurse, referring to LPN-A, failed to follow the five rights of medication administration (right medication, right dose, right route, right time and right patient). LPN-A failed to check the correct dose. In addition, she did not verify the dose with another nurse per facility policy. The nurse manager on duty found the medication error around 12:30 a.m. on 4/12/25 in the system because the order had not been verified with another nurse. RN-A immediately reached out to LPN-A to verify the medication error and notified the NP for new orders. RN-A stated all staff had been retrained following the incident. Upon interview on 4/17/25 at 11:01 the NP stated on 4/11/25 he was informed that R1 was having difficulty eating, breathing and was agitated. He ordered R1 to have oxygen and if his breathing did not improve to send him to the hospital. R1's family did not want him sent to the hospital, so the NP ordered liquid morphine 5 mg (20 mg/1 ml). He ordered the morphine in liquid form because that was available in the emergency medication kit. At around 12:30 a.m. he was notified that R1 received an incorrect dose of morphine. The NP gave the orders to hold the morphine and monitor R1 frequently. The NP was under the impression R1 received 20 mg of morphine and was not told until the following day that R1 instead received 100 mg of morphine. The NP stated he was not certain if the overdose caused R1's death. He stated the Medical Examiner will make that determination. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview on 4/17/25 at 1:42 p.m. RN-B stated she worked as the facility manager the night of 4/11/25. She was given report by the outgoing manager RN-C that R1 had a change in condition, the NP was notified and had placed an order for oxygen and morphine. RN-B stated she received the hard copy verbal order of the morphine. She checked the order to ensure there were two signatures on the order. She got the medication out of the emergency (e)-kit and delivered it to LPN-A around 11:30 p.m. RN-B handed the medication vial to LPN-A and another LPN staff member signed the managers book that the medication was delivered. RN-B left the unit and went to complete other assignments. At approximately 12:30 p.m. RN-B noticed R1's morphine order had not been confirmed in R1's electronic chart (e-chart). She was concerned because medications were not to be given until two nurses had confirmed the ordered dose in the e-chart. RN-B went to the unit and asked LPN-A why she had not administered R1's morphine. LPN-A told RN-B she had administered the morphine at 11:45 p.m. RN-B noticed that LPN-A had written down 5 ml administered. RN-B asked LPN-A how much morphine R1 received, and LPN-A told her 5 ml. RN-B stated she knew it was the wrong dose and calculated the error. RN-B's calculation indicated R1 received 20 mg of morphine. RN-B called the NP and reported R1 had been given 20 mg of morphine instead of 5 mg. The NP ordered staff to hold the morphine and to monitor R1. RN-B told the family, who was in R1's room that R1 had been given 20 mg of morphine instead of 5 mg and the facility would be holding the morphine and monitoring R1 frequently. The family still wanted R1 to stay at the facility and not be sent to the hospital. RN-B brought in cots for the family to spend the night with R1. At approximately 2:15 a.m. RN-B received a call from LPN-A stating R1's oxygen saturations were trending down in the 70's. RN-B elevated R1's head of bed and got him a face mask for the oxygen instead of the nasal cannula. At approximately 2:40 a.m. LPN-A told RN-B that she thought she may have given R1 more than 20 mg of Morphine. RN-B looked at the morphine bottle again and what LPN-A had given and realized she had given him 100 mg of Morphine instead of the 20 mg they had thought prior. RN-B paged the NP, as she was paging him, she was told R1 had passed away. After confirming R1's passing and consoling the family, RN-B met with the family and told them R1 received more morphine than they originally thought he received, it was 100 mg of morphine at 11:45 p.m. and 20 mg was previous reported to the family. RN-B stated the facility provided training to all licensed staff following the error. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview on 4/17/25 at 6:22 p.m., family member (FM)-A stated she had spoken with RN-A a few days prior to R1's death regarding R1's change in condition. FM-A was told R1 required more assistance with feeding and was sleeping more. A plan was made that R1 would stay at the facility and not be hospitalized if he declined further. On 4/11/, FM-A and FM-B were with R1 at dinner time and assisted with his feeding. They left the facility around 7:00 p.m. At approximately 10:00 p.m. FM-A received a call from the facility stating R1 was agitated, and his oxygen saturations were under 90% and they wanted to send R1 to the hospital. FM-A stated not to send him to the hospital that she and FM-B were on their way to the facility to see him. They arrived at the facility around 10:30 p.m. R1 was anxious, pulling at his blankets and his breathing seemed more labored. R1 was wearing oxygen when they arrived, however his saturations continued to be below 90%. RN-C told FM-A that the NP ordered some morphine to relax R1 and assist with the breathing. FM-A was agreeable. At 11:45 p.m. LPN-A administered the morphine to R1. LPN-A had to awaken R1 to administer the morphine. R1 stayed awake and was breathing harder, sounded like sleep apnea although he was awake FM-A asked staff to please leave the O2 monitor on R1, which they did. R1's saturations continued to drop. At approximately 12:30 p.m. LPN-A told the family she had accidentally given R1 20 mg of morphine instead of 5 mg, that the NP had been notified, and the staff would be monitoring R1 frequently. At approximately 12:40 p.m. RN-B entered the room and explained the medication error to the family again. RN-B recommended the family spend the night and brought in cots to sleep on. FM-A stated over the next few hours R1 became worse, his saturations continued to drop, he was agitated and then he went into a coma state where his pupils looked to be pinpoint. He still had a pulse at 1:50 a.m. At approximately 2:00 a.m. FM-A stated R1 started the death rattle which was confirmed by RN-B. RN-B told FM-A she thought R1 was dying and to notify the rest of the family. After R1's passing at 2:50 a.m. RN-B told the family R1 had received 100 mg of morphine. Attempts to contact LPN-A were unsuccessful. A facility protocol titled Medication Administration Protocol with a revision date of 4/2025 indicated: Medication/Treatment Administration Procedure: A. Perform hand hygiene. B. Unlock medication cart. C. Open resident's electronic health record (HER) and choose eMAR. D. Identify medication/treatment to be administered. E. Check for resident allergy. F. Locate medication card/container and compare the label with the eMAR directions. 1. Check the label for: a) Right resident b) Right drug - check label description for color and shape c) Right dosage (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d) Right route e) Right time In addition: Special instructions: a) Liquid narcotic medication: two nurses must verify the amount to be given. Liquid narcotic medication requiring a dosage calculation must be transcribed in PCC order in ml and verified at time of transcription by two nurses. A facility policy titled Medication Administration with a revision date of 12/4/2024 indicated: Staff administering medication must ensure the correct medication is administered in the correct dose, in accordance with the manufacturer's specifications or provider's order, to the correct person via the correct route in the correct dosage form and at the correct time. Medication incidents that result in certain types of medication errors for the resident (Such as the wrong person, drug, dose, route, frequency, lack of clinical justification, or charting omissions) must be documented and reported by staff to nursing leadership as applicable. Following survey the DON sent the policy and protocol which were in the investigative file. The IJ that began on 4/11/25, was corrected on 4/14/25. The IJ was issued at past noncompliance due to the actions the facility implemented prior to survey, including: The facility identified the error on 4/11/25 and completed a thorough investigation identifying the root cause that LPN-A did not follow the medication right or right dose and did not verify the dose with another nurse. LPN-A was placed on a leave pending the investigation on 4/14/25. All nursing staff were educated on the medication order transcription process, order confirmation process, ensuring orders are confirmed and appear on the electronic medication record prior to administration, double noting of liquid narcotics to ensure correct dosing on order and in the narcotic book. This was completed on 4/14/25. IDT meeting was held to discuss the use of liquid narcotics in the facility vs. sublingual morphine to propose the change to the pharmacy for emergency medication kit use on 4/14/25.