STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnesota Veterans Home - Silver Bay	56 Outer Drive Silver Bay, MN 55614

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** 47790 Based on interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R1) reviewed for medication errors. This failure resulted in actual harm for R1 when she developed bradycardia (abnormally slow heart rate) and became hypotensive (abnormally low blood pressure) which required ongoing monitoring in the emergency department (ED). The facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition, and had diagnoses of chronic kidney disease stage 3b (moderate to severe loss of kidney function), hypertension (high blood pressure), heart failure (heart muscle does not pump blood effectively), hyponatremia (low blood sodium), anemia (low red blood cells), and polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness) . A facility report to the State Agency (SA) on 1/7/25 indicated on 1/6/25 at 7:45 a.m. R1 received another resident's medications, and had been sent to the hospital. On 1/6/25 at 9:14 a.m., a progress note written by nurse practitioner (NP)-A, indicated R1 had symptomatic hypotension and bradycardia following a medication error. R1 reported severe dizziness. Order written for evaluation and treatment at the ED. R1's Weights and Vitals Summary dated 1/6/25, indicated R1 had a blood pressure of 67/40 and pulse was 47 at 9:14 a.m. At 9:39 a.m. R1's blood pressure was 61/40 and her pulse was 41 bpm. R1's Emergency Department Note dated 1/6/25, indicated R1 was given the following medications the morning of 1/6/25: acetaminophen 650 milligrams (mg), apixaban (blood thinner) 5 mg , carvedilol (heart medication) 25 mg, divalproex sodium (seizure medication) 125 mg, furosemide (diuretic) 40 mg, metformin (diabetic medication) 1000 mg, sacubitril-valsartan (heart medication) 97-103 mg, allopurinol (uric acid reducer) 100 mg, amlodipine (blood pressure medication) 100 mg, empagliflozin (diabetic medication) 10 mg, ferrous sulfate (iron) 234 mg, isosorbide mononitrate extended release (heart medication) 60 mg, paroxetine (antidepressant) 20 mg, tamsulosin (prostate medication) 0.4 mg, and zinc sulfate 220 mg. (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 - Actual harm Residents Affected - Few	R1's hospital History and Physical Summary dated 1/6/25, indicated R1 was accidentally given the wrong medications on the morning of 1/6/25. R1 had the following symptoms: lightheadedness, weakness, hypotension, and sinus bradycardia with rate in the mid to upper 40s. Poison control was contacted and didn't have further recommendations other than monitoring R1's blood pressure and heart rate. R1 was placed on telemetry, vital signs were completed every 2 hours, intravenous (IV) therapy was started with normal saline at 100 cubic centimeters per hours (cc/hr). Creatinine level (indicates how well the kidneys are functioning) was within baseline at 1.6 milligrams per deciliter (mg/dL). Hemoglobin (a protein in red blood cells) was stable at 9.4 grams per deciliter (g/dL). Orders were placed to recheck hemoglobin on 1/7/25. Electrolytes were within normal limits. On 1/14/25 at 11:52 a.m., R1 stated on 1/6/25 in the morning, she was told by staff that she got the wrong medications. R1 stated she felt dizzy and weak in her legs a few hours after taking the wrong medications. R1 stated she had to go to the hospital overnight because she was not feeling well. On 1/15/25 at 8:46 a.m., registered nurse (RN)-A stated on 1/6/25 during the morning medications pass, she set up three different residents' medication in the medication room, and placed them on a tray. She took the tray and went into R1's room to give R1 her medications. She gave R1 the wrong medications, but did not realize until she went to the second resident's room and his medications were not on the tray, but R1's medications were still on the tray. She went and told the charge nurse right away. The charge nurse then took over caring for R1. RN-A was removed from passing medications to being a nursing assistant for the day. During her lunch, she was told she needed to leave the facility pending investigation, and has not been back to the facility since the incident. She had since been re-educated, and was now aware that pre-preparing medications was not an acceptable practice, and she would not be doing it in the future. On 1/15/25 at 9:56 a.m., consultant pharmacist (P)-A stated after she reviewed the medications R1 received in error, she was concerned about R1's blood pressure as she received high doses of blood pressure medications. It would not be acceptable for nurses to prepare more than one person's medications at one time ever. On 1/15/25 at 11:48 a.m., NP-A stated she found out R1 was given the wrong medications on the morning of 1/6/25, and became worried about R1's blood pressure, pulse, alertness, and level of consciousness. She told the facility to send R1 to the ED when her blood pressure and pulse dropped, and she was complaining of dizziness. She would expect staff to complete one resident's medications at a time. It would never be accepted to do set up multiple resident medications at one time. On 1/15/25 at 12:04 p.m., the director of nursing (DON) stated the process of staff passing medications was to follow the medication rights, and do prepare medications for one resident at a time. The policy was not followed by RN-A on 1/6/25. The facility had reviewed the medication administration and medication incident policy, revised the medication administration standards policy, reviewed R1's care plan, started medications administration audits, provided education to nurses in regards to medication pass expectations, and P-A would be coming on 1/30/25 to do more education on medication administration. The facility Medication Administration policy revised 12/4/24, identified staff administering medication would ensure the correct medication was administered 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. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The facility implemented corrective action to prevent recurrence by 1/14/25 when the facility completed the following: Reviewed and revised medication administration policies, provided education to all staff members responsible for medication administration, which included administration of medications and ensuring the six rights of medication administration was being followed, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview, and document review on 1/14/25 and 1/15/25.