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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E150	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Avenue Rest Home	3956 Grand Avenue S0uth Minneapolis, MN 55409

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 Based on interview and document review, the facility failed to ensure a once monthly injection was administered per physician orders, resulting in the monthly injection being administered twice over two days for 1 of 4 residents (R1) reviewed for medication errors. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE] indicated R1 was cognitively intact and independent with activities of daily living. R1's Face Sheet dated 7/18/24 indicated R1 had diagnoses of schizoaffective disorder, bipolar disorder,and extrapyramidal movement disorder (brain abnormalities that can lead to motor deficits). R1's Physician Order started 7/4/24 directed Invega Sustenna (Antipsychotic) Intramuscular Suspension Prefilled Syringe 234 milligrams/1.5 milliliters (Paliperidone Palmitate). Inject 1 dose intramuscularly one time a day every 28 days related to schizoaffective disorder. R1's care plan dated 7/10/24 indicated on 7/3/24, due to increased behaviors, nursing reviewed medication records and discovered that Invega injection was not given as ordered on 6/12/24. A dose was given on 7/3/24. On 7/4/24 resident received a second dose of Invega due to nurse not recording first dose on the medication administration record (MAR). Nursing staff will monitor blood pressure every shift, monitor resident for any unusual neck movement/muscle twitching for next 24 hours. R1's Physician Order dated 7/4/24 through 7/6/24, to Check blood pressure each shift for 48 hours, document on any abnormal neck movement or muscle twitching and make appointment for psych as soon as possible. R1's June MAR indicated an order for Invega Sustenna Suspension Prefilled Syringe 234 milligrams/1.5 milliliters. Inject 1.5 ml intramuscularly one time a day every 28 days for schizoaffective disorder. The start date was 11/02/22 and was discontinued on 7/4/24. The medication was scheduled for 6/12/24. The MAR indicated the medication was held on 6/13/24 and was not given during the month of June. R1's July MAR indicated the Invega injection was given only on 7/4/24. The MAR lacked indication the injection was administered on 7/3/24. (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 Grand Avenue Rest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 Grand Avenue S0uth Minneapolis, MN 55409	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 4:20 p.m., a progress note indicated a return call was received from nurse practitioner (NP)-A to administer the Invega injection 234 milligrams intramuscular one time now. The staff nurse was updated with the new order. On 7/3/24 at 4:35 p.m., a progress note indicated a review of R1's electronic medical record was completed. R1 had last received the Invega injection in May 2024. A call was placed to R1's psychiatry clinic which was closed. A message was left for R1's primary care provider to request a new order for Invega. On 7/3/24 at 6:30 p.m., a progress note indicated licensed practical nurse (LPN)-A received a phone order from the director of nursing (DON)-A to administer the Invega suspension. LPN-A administered the medication as instructed from the phone call from the DON. On 7/4/24 at 10:50 a.m., a verbal phone order was given by nurse practitioner (NP)-A. The order was Invega Sustenna Suspension Prefilled Syringe 234 milligrams/1.5 milliliters. Inject 1.5 milliliters Intramuscularly one time a day every 28 days for schizoaffective disorder. The discontinue/reason was schedule updated. On 7/4/24 at 4:00 p.m., a physician note signed by medical doctor (MD)-A indicated MD-A was notified R1 had received the Invega injection back-to-back within two days in error. MD-A spoke to poison control. The nursing staff were directed to be vigilant to prevent falls, dystonic reactions, or autonomic instability. If any of those signs were to develop, R1 was to be brought to the hospital. It was recommended nursing staff reach out to R1's psychiatrist and schedule the earliest available appointment. On 7/4/24 at 9:48 a.m., a progress note indicated a call was made to R1's psychiatric clinic to report that R1 had missed the June dose of Invega, but there was no psychiatry staff available. Another call was made to NP-A. NP-A directed to give the Invega and resume the 28-day schedule. On 7/4/24 at 11:18 a.m., a progress note indicated the resident received the Invega injection. On 7/4/24 at 11:47 a.m.,a progress note indicated LPN-B received a verbal order from DON-B to give the Invega injection. After LPN-B gave the injection, she received a call from DON-A. DON-A told LPN-B that the injection was already given the day before. LPN-B had checked progress notes and R1's medication administration record and did not see documentation that the injection was given on 7/3/24. LPN-B called R1's psychiatrist and left a message for the on-call physician. On 7/5/24 at 1:04 p.m., a progress note indicated R1 was alert and able to respond to the questions. She went on a chaperoned trip to the store. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 10:49 a.m., LPN-A stated she was working on 7/3/24. DON-A had been working on the follow up for R1's missing injection. DON-A left and later called LPN-A directing her to give the injection since DON-A had heard back from NP-A. LPN-A was waiting for the order to be put in R1's electronic medical record so she could document that it was given but LPN-A never saw the order come through. LPN-A stated she felt she had to do what DON-A said since she was the director. The next day, LPN-A received a phone call from DON-A asking if LPN-A gave the injection, which she did. LPN-A then found out someone else gave the injection again. LPN-A stated the day she gave the injection she did not enter a progress note, but she did the following morning. Instead, she wrote a handwritten note stating she gave the injection and left it on DON-A's desk. LPN-A stated she was able to enter orders into PCC herself but since she did not receive the order from the NP, she thought DON-A would do that. LPN-A stated she had received education about administering medications without a physician's order, but at the time of the incident she was confused since DON-A gave her an okay to give it. On 7/19/24 at 11:32 a.m., the administrator stated he was not directly involved with the incident because DON-B said he would take over the investigation after the missing dose was discovered. DON-B called the provider to see if it was okay to administer it and checked R1's progress notes and electronic medical record and did not find any indication that the injection had already been given. DON-B then directed LPN-B to give the injection after the MD stated it was okay to administer it. Once staff realized R1 was given the injection twice they immediately started monitoring and updating the providers. The director stated LPN-A and LPN-B had received education on medication administration. DON-A and DON-B had not yet received education on how to direct nursing staff to give medication following verbal or written orders from the provider. The administrator stated this was related to the facility's previous administrator leaving the week prior to the medication error and the administrator is now in charge of three facilities but the education was still in progress. On 7/19/24 at 11:53 a.m., DON-A stated there was care conference for R1 on 7/3/24 because R1 had been declining. While going through her medication administration records, she noted an omission for the injection on 6/12/24. She immediately began the investigation and had calls out to the provider. The medication was initially missed was because R1 was discharged from the hospital late on 6/12/24. The day nurse marked it as held, but the next nurse did not administer it once R1 returned to the facility on [DATE]. A social worker was present at the 7/3/24 care conference and alerted the administrator and DON-B from the sister facility of the medication error. After DON-A had left work for the day, NP-A called back and stated it was okay to give the injection following the missed dose. She called LPN-A to give the injection. LPN-A didn't know where to document the administration, so she just left a note for DON-A to read. The next day, DON-B directed LPN-B to give the medication, but DON-A had never received a call from DON-B asking about the status of the medication error. DON-A was not working on 7/4/24 but still called to check in on the facility. DON-A called LPN-B who asked why DON-B was asking her to give the injection. DON-A immediately called the administrator, and it was discovered the medication had been given twice in error. She had taken time off, and when she received the call late in the day on 7/3/24 from NP-A, she did not have the ability to enter the order in the electronic health record. It was an unusual situation trying to put it together. The correct way to document the medication was given was for the nurse who received the order to enter it in the system, but LPN-A did not make that concern known to her. Everyone was well intended, but there were too many people working on the issue. R1 was monitored and did not experience any adverse side effects related to the medication errors. Phone calls requesting interviews were made to NP-A, the pharmacist and LPN-B, but were not returned. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy pertaining to verbal and written orders was requested but not received. The facility policy Administering Medications last revised 2/26/24 directed medications are administered in accordance with prescriber orders. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method before giving the medication.