STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayo Clinic Health System - Lake City	500 West Grant Street Lake City, MN 55041

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** 38685 Based on observation, 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 when R1 became hypotensive that required treatment in the emergency department (ED) and ongoing symptom monitoring and treatment. 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], identified R1's cognition was intact and had diagnoses of chronic kidney disease stage 3b (moderate to severe loss of kidney function) and hyponatremia (low blood sodium). R1's order summary dated 11/18/24, identified R1 was to receive the following oral medications in the morning: acetaminophen (for back pain)1000 milligrams (mg), aspirin (for stroke prophylaxis) 81 mg, citalopram (for depression)10 mg, and multivitamin. R1's medication administration record (MAR) dated 12/10/24, identified none of the above scheduled am medications were given, a 9 was documented and indicated, other, see nurses note. R4's order summary dated 12/4/24, identified R4 was to receive the following oral medications in the morning: lisinopril (for high blood pressure) 10 mg, calcium 500+D tablet (for osteoporosis) 500-10 mg-micrograms (mcg), and sennoside-docusate sodium (for constipation) 8.6-50 mg tablet. R4's medication administration record (MAR) dated 12/10/24, identified lisinopril, calcium 500+D and sennoside-docusate sodium were given at 6:47 a.m. R1's Medication/Treatment Error Report dated 12/10/24 at 8:30 a.m., identified lisinopril was given to the wrong resident, the nurse was new and on their own for the first time today. Immediate effects noted were R1 reported dizziness and a drop in blood pressure (normal blood pressure range is below 120/80 but above 90/60). Provider notified at 8:30 a.m. and ordered to check blood pressure every 30 minutes until systolic blood pressure (SBP) was greater than 90, push fluids, send to emergency department (ED) if SBP stays in the 70's and symptomatic with dizziness and hypertension. R1's Medication Error/Event Root Cause Analysis form dated 12/10/24, identified the error category E level (an error that could have caused temporary harm). (continued on next page)

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 progress note dated 12/10/24 at 8:25 a.m., identified R1 was dizzy, weak, not feeling well and hypotensive. Blood pressure (B/P) 72/40, encouraged and assisted with pushing fluids, notified on call provider by phone, new order to check blood pressure every 30 minutes, if remained symptomatic and systolic remained in 70's send to ER. R1 inadvertently received 10mg lisinopril this am. Family members came to care center to visit and were updated on the situation. R1's progress note dated 12/10/24 at 9:20 a.m., identified R1 was sent to the ED with family accompanying for diagnosis of hypotension. Blood pressure was re-checked and was 64/43, continued to have symptoms of dizziness and would not drink fluids with encouragement and assistance. R1's Vitals summary identified the following blood pressures: 12/10/24: -8:33 a.m., was 72/40. -9:00 a.m., was 64/43. -9:20 a.m., was 88/52. R1's Emergency Department (ED) summary dated 12/10/24, at 9:28 a.m., identified R1's blood pressure was 89/49 and the reason for visit was hypotension (care center called and stated R1 was given lisinopril in error and pressures were 60's/40's with dizziness). Assessment and plan identified evaluation for hypotension due to receiving lisinopril in error at 6:47 a.m., antihypertensive effect of lisinopril started within 2 hours and will peak at 6 hours, gave IV fluids in attempt at improvement of hypotension. At 10:51 a.m., R1 has no urge to urinate, gave another liter of fluids, blood pressure still low at 74/45, nausea was better. At 12:02 p.m., blood pressure 82/47 progressive improvement, lowest blood pressure earlier was 68/44. At 12:23 p.m., R1 has no urge to urinate, felt better after receiving 2 liters of fluids, gave another liter of fluids and monitor blood pressure closely. At 12:53 p.m., blood pressure 97/51, at 2:35 p.m., blood pressure 102/61 improved with sitting, and at 2:45 p.m. blood pressure 121/63 increased with movement. At 2:48 p.m. Zofran given for nausea. At 3:09 p.m., R1 hypotensive again at rest, R1 would like to go back to the care center as soon as possible, will hold off on anymore fluids, no lightheadedness with standing. At 3:32 p.m., R1 had a liter of watery output from ileostomy while at ER, will give does of albumin to attempt at improvement of hypotension at rest. At 5:12 p.m., mean arterial pressures (MAP's) - (represents the average pressure in your arteries throughout the cardiac cycle, indicating how well your organs are being perfused with blood, most people need a MAP of at least 60 to ensure blood flow to vital organs) consistently remaining in the 60's. R1 would like to be discharged home will have nursing home staff monitor blood pressure this evening and tomorrow morning. Return to ER with concerning signs and symptoms, R1 discharged back to nursing home at 5:35 p. m. R1's progress note dated 12/10/24 at 5:50 p.m., identified R1 returned to the facility via wheelchair at 5:30 p. m. with family present. R1 received 3L of IV fluids and 500 ml of albumin. Output of 1300 ml out of ostomy. Resident asymptomatic at this time, just weak and tired. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 12/11/24 at 10:16 a.m., identified blood pressures were 72/45 and 69/35. After pushing fluids and eating blood pressure was 90/53. R1 was seated at the edge of her bed for all blood pressures. Denied dizziness, nausea, vertigo, or any other symptoms. R1 reported feeling tired. R1's progress note dated 12/11/24 at 10:47 a.m., identified R1 was asymptomatic and felt better. Blood pressure was 88/58 while lying in bed. reported no urine output since yesterday, new order to check blood pressure every 4 hours and as needed, if symptomatic and SBP <80 notify provider. R1's Video Nurse Practitioner visit dated 12/11/24, identified an evaluation regarding concern about acute urinary retention with hypotension noted over the past 24 hours. R1's blood pressure was 76/43. R1 continued to have poor urinary output was continent of urine and stated she had gone twice this afternoon. R1 had post void bladder scan which noted retention of 322 ml. New Orders to check basic metabolic panel (BMP) (blood test to monitor blood pressure and kidney disease) and post void bladder scan for 3 days to assess decreased urinary output. With each post void scan, if >300 milliliters (ml) then in and out Cath to completely empty bladder. R1's Vitals summary identified the following blood pressures: 12/10/24 at 9:36 p.m., was 88/52. 12/11/24: -12:31 p.m., was 76/43. -6:23 p.m., was 97/46. -9:23 p.m., was 87/48. 12/12/24: -2:32 a.m., was 94/51. -4:53 a.m., was 119/59. -10:00 a.m., was 111/64. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 12/17/24 at 2:35 p.m. R1 was lying in bed with a blanket covering her. R1 stated one of the staff gave her the wrong medication, it was a blood pressure medication. R1 indicated on the morning of 12/10/24, she got up at 6:15 a.m., was given her pills, and then a short while later she started to feel dizzy and weak. When she went to the bathroom to get ready for the day, she looked in the mirror and could not see herself, everything was fuzzy, that's when she told, the girls, she was nauseated and would not be able to eat breakfast. R1 indicated at some point they were checking her blood pressure over and over and it was pretty low, so they sent her to the ER. R1 stated she was scared because she did not feel right from getting the wrong medication and had to spend most of the day in the ER and was given several IV fluids. R1 stated ever since she was given the wrong medication, she has been weak, had not had an appetite and both legs between her knees and her hips hurt even when she wasn't doing anything but lying in bed. R1 indicated she never had the leg pain until the day they gave her the wrong medication. R1 stated she had the pain if she stood too long and stated the left leg had gotten better but not the right leg, R1 stated the pain was a steady pain and was experiencing it in her right leg at this time. During a phone interview on 12/17/24 at 1:58 p.m., registered nurse (RN)-B indicated on 12/10/24, it was his first day to independently pass medications. RN-A stated he had mistakenly given R1 lisinopril that was meant for R1's roommate. RN-A stated he didn't realize it until R1 was exhibiting hypotension, dizziness, nausea, blurred vision, lightheadedness, and weakness. RN-A verified R1 was sent to the ED for treatment of hypotension. RN-A stated he was educated on the medication administration policy, the 5 rights of medication, and had additional training. During an interview on 12/18/24 at 9:18 a.m., registered nurse (RN)-A stated RN-B told her on 12/10/24 around 8:30 a.m., that he had given R1 lisinopril in error that was meant for R4. She was given the medications at 6:47 a.m. RN-A stated R1 was assessed and noted to be weak, dizzy, and nauseated with systolic blood pressures in the 70's. RN-A indicated she called the provider to notify of R1's medication error was given new orders to monitor blood pressures and to send to the ER if blood pressures did not come up. RN-A stated R1 was being monitored closely by nursing staff and the providers and was sent to the ER at around 9:30 a.m. RN-A stated RN-B was immediately supervised for the remainder of the shift, was re-educated, and had additional training. During an interview on 12/18/24 at 12:24 p.m., director of nursing (DON) indicated on 12/10/24 R1 had received her roommates lisinopril that caused R1 to be transferred to the ER to be treated for hypotension. DON indicated this was a significant medication error because of the adverse side effect of hypotension. DON indicated RN-B was responsible for the medication error, root cause was incorrect -RN-B was immediately re-educated, had another nurse assist him that day. DON indicated immediately all staff were re-educated on the 5 rights of medication and the medication administration policy had been performing medication administration audits to ensure compliance. During a phone interview on 12/18/24 at 1:04 p.m., consultant pharmacist (CP)-A indicated if a resident without the diagnosis of high blood pressure was given lisinopril in error the resident would need to be monitored closely for low blood pressure and would be considered a significant medication error. CP-A indicated the effects of 10 mg of lisinopril would take effect within 2 hours of ingestion, peak at 6 hours and can last for up to 24 hours. CP-A stated lisinopril can lead to dehydration and side effects would be nausea, dizziness, fatigue, and headache. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/17/24 at 1:40 p.m., medical director (MD)-A stated R1 was given 10 mg of lisinopril on 12/10/24 that resulted in a significant medication error. MD-A indicated R1 had kidney disease and had to be sent to the ER to have her blood pressures monitored along with her kidney function and was treated with IV fluids and IV albumin; albumin can help raise blood pressure by drawing fluid back into circulation. MD-A stated after the ER visit R1 was having trouble with not making any urine which was a sign of the kidneys not working properly. MD-A further stated there will be further assessments, labs, and monitoring for R1 to return to baseline. Facility policy, Medication Administration Guidelines revised 3/10/23, identified Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 7. Residents are identified before medication is administered using two methods of identification. Methods of identification include a) By checking the resident's name band, b) By asking a reliable resident for his or her first and last name, c) By referring to the photo attached to the EMAR record and d) If necessary, verifying resident identification with other facility personnel . 10. Check for the five rights: the right resident, the right medication, the right dosage, the right route, and the right time . 17. Medications supplied for one resident are never administered to another resident. During the onsite visit on 12/17/24 and 12/18/24, the facility's corrective actions were verified as implemented on 12/10/24, prior to the survey visit, therefor this deficient practice is being cited as Past Non-compliance. Corrective actions included: -On 12/10/24, the facility completed an investigation and causal analysis -On 12/10/24, RN-B was immediately re-educated and supervised. -On 12/10/24, provided educated to licenses and unlicensed staff regarding giving medications as ordered and medication administration policy.