DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 1, 2023

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: May 3, 2023

Dear Administrator:

On May 25, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2023

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

Re: Reinspection Results
Event ID: 4BL012

Dear Administrator:

On May 25, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 3, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2023

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: May 3, 2023

Dear Administrator:

On May 3, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 3, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 3, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2023

Administrator
Mahnomen Health Center
414 West Jefferson Avenue
Mahnomen, MN 56557

Re: State Nursing Home Licensing Orders
Event ID: 4BL011

Dear Administrator:

The above facility was surveyed on May 1, 2023 through May 3, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/1/23 through 5/3/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/1/23 through 5/3/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency(s) issued: H52381766C (MN90331) H52381714C (MN92999) H52381786C (MN84150) H5238041C (MN82984) H5238042C (MN76722) H5238043C (MN74288) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication error rates were 5 percent or less for 3 of 11 residents (R4, R18, R26) observed during medication administration. Findings include: R4's physician order dated 3/8/23, inlcuded calcium carbonate-vitamin D3 600 mg-200 international units (iu) tablets. Take one tablet by mouth twice a day. During observation on 5/1/23 at 7:02 p.m., registered nurse (RN)-A administered one tablet of calcium-vitamin D3 600 mg - 400 iu to R4. During an interview on 5/3/23 at 9:41 a.m., licensed practical nurse (LPN)-A stated the medication dosage on the bottle and provider prescribed dosage did not match. Because of this, the physician should have been contacted. During an interview on 5/3/23 at 9:42 a.m., LPN-B	F 759	05/03/2023-05/04/2023: Education was provided immediately to all nurses and TMA□s employed at this time in regards to proper labeling of medication, the 5 medication checks, comparing the label to the order in the MAR and labeling of stock medications brought in by families. All nurses/TMA□s were trained via in person or zoom. This information was added to the orientation checklist to ensure new nurses/TMA□s are educated on these items. Medication cart audits will be completed weekly until improvement noted through QAPI. Audits will then be completed based on QAPI recommendations. 05/04/2023: A complete medication cart audit was performed to ensure all medication labels for all residents□ matched the MAR and provider order and that all OTC medications are labeled with resident name. 05/08/2023 audit was completed. 05/08/2023: To ensure continued	5/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 2 stated R4's calcium with vitamin D order was the same order since 2019. The order was recently reviewed and signed by primary care provider (PCP)-A on 3/8/23. Anytime a medication dosage and physician's order does not match, staff would need to contact the PCP. During a telephone interview on 5/3/23 at 9:44 a.m., pharmacist (P)-A stated the pharmacy records identified RN-B called in the order for calcium carbonate - vitamin D3 600 mg - 400 iu one tab by mouth twice a day on 7/20/22, . P-A stated the medication dose was not equivalent to the medication ordered. R18's physician order dated 6/30/22, identified to discontinue timolol ophthalmic eye drop (focused to treat open-angle glaucoma and other causes of high pressure inside the eye) in left eye and continue latanoprost eye drop (treat high pressure inside the eye due to glaucoma [open angle type] or other eye diseases such as ocular hypertension, ophthalmic-intraocular pressure reducing agents, prostaglandin analogs) in both eyes at bedtime. During observation on 5/2/23 at 4:04 p.m., LPN-C administered timolol 0.5% one drop to the left eye. During a telephone interview on 5/3/23 at 12:02 p.m., LPN-C stated the process for ordering medications was done electronically. The medication was received from the pharmacy in a locked bag with a packing slip for the nurse to check off medications received. If LPN-C was unsure of a correct medication, she could use her phone or drug book to verify the correct medication. Further, timolol eye drops and	F 759	accuracy, all meds sent from pharmacy are checked upon arrival and compared to the MAR for accuracy. Random weekly audits will be done by clinical care coordinator, MDS coordinator or designees until improvement has been noted. Further audits and will be completed based on QAPI recommendations. 05/08/2023 Random weekly medication audits will be done on all OTC medications to ensure they are labeled appropriately until improvement is noted. Further audits will be completed based on QAPI recommendations. All audits will be monitored through QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 3 latanoprost eye drops were not the same. LPN-C shouldn't have given the timolol eye drop because it was discontinued. The nurse should have double checked the order and called the pharmacy for the correct medication when the medication was received. During interview on 5/3/23 at 1:34 p.m., director of nursing (DON) stated sometimes the physician discontinues a medication at the nursing home and forgets to take it off clinic chart and the pharmacy continues to refill the prescription. R26's physician order dated 4/18/23, included citrus calcium-vitamin D3 200 mg -250 iu tablets. Take one tablet by mouth twice a day. During observation on 5/1/23 at 6:11 p.m., RN-A administered calcium-vitamin D 600 mg-400 iu one tab by mouth to R26. During interview on 5/3/23 at 8:36 a.m., LPN-A stated family brought in an over-the-counter bottle of calcium with vitamin D. The bottle's manufacturer label identified each tablet contained calcium-vitamin D 600 mg -400 iu. Further, the dosage on the manufacturer label did not match the physician's order. During an interview on 5/3/23 at 9:38 a.m., LPN-B stated family brought in the over-the-counter bottle of calcium with vitamin D for R26. The medication should have been verified against the physician's order prior to use. If the medication dosage was not correct, nursing should contact the physician for guidance. During a telephone interview on 5/3/23 at 9:47 a.m., P-A stated the pharmacy had not delivered	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 4 calcium-vitamin D 600 mg -400 iu for R26. The medication dose given was not equivalent to the medication ordered. During a telephone interview on 5/3/23 at 1:45 p.m., PCP-A stated staff should reach out to him with any medication discrepancies to prevent a medication error. During an interview on 5/3/23 at 2:39 p.m., DON stated staff should perform the five rights of medication administration (the right dose, the right medication, the right resident, the right route and the right time) to reduce medication errors. Staff should utilize resources such as the physician, the pharmacy and/or online drug references if there are discrepancies. The policy Medication and Treatment Administration dated 2023, identified when drugs were administered, staff should verify the correct resident, medication, time, route and dose by referring to the medication administration record (MAR).	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		5/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 5 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an over the counter (OTC) prescribed medication was labeled with the resident name for 1 of 11 residents (R26) observed during medication pass and who's medication was not labled. Findings include: R26's physician order dated 4/18/23, included an order for citrus calcium-vitamin D3 200-250 milligram (mg) tablets. Take one tablet by mouth twice a day. During an observation on 5/1/23 at 6:11 p.m., registered nurse (RN)-A administered one tablet of calcium with vitamin D to R26. The medication bottle was not labeled with R26's name or directions for use. The manufacturer label on the bottle identified calcium 600 mg along with 400 iu of vitamin D. The physician's order was citrus calcium-vitamin D3 200-250 milligram (mg) tablets. Take one tablet by mouth twice a day.	F 761	05/03/2023-05/04/2023: Education was provided immediately to all nurses and TMA's employed at this time in regards to proper labeling of medication, the 5 medication checks, comparing the label to the order in the MAR and labeling of stock medications brought in by families. All nurses/TMA's were trained via in person or zoom. This information was added to the orientation checklist to ensure new nurses/TMA's are educated on these items. Medication cart audits will be completed weekly until improvement noted through QAPI. Audits will then be completed based on QAPI recommendations. 05/04/2023: A complete medication cart audit was performed to ensure all medication labels for all residents' matched the MAR and provider order and that all OTC medications are labeled with resident name. 05/08/2023 audit was completed.	

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F 761	Continued From page 6 During an interview on 5/3/23 at 8:36 a.m., license practical nurse (LPN)-A stated family brought in R26's bottle of calcium 600 mg along with 400 iu of vitamin D. The bottle lacked identifying markers that the calcium 600 mg along with 400 iu of vitamin D belonged to R26. The bottle should have been labeled directing who's medication it was. During an interview on 5/3/23 at 9:38 a.m., LPN-B stated R26's family brought in all of R26's over the counter medications. When the medication was received, the nurse should have written R26's name on bottle. During a telephone interview on 5/3/23 at 9:47 a.m., the pharmacist stated the pharmacy did not deliver calcium 600 mg along with 400 iu of vitamin D. The pharmacist failed to identify the process for labeling an OTC medication brought in by family. The policy Medication and Treatment Administration dated 2023, lacked labeling directions for medications brought in by family.	F 761	05/08/2023: To ensure continued accuracy, all meds sent from pharmacy are checked upon arrival and compared to the MAR for accuracy. Random weekly audits will be done by clinical care coordinator, MDS coordinator or designees until improvement has been noted. Further audits and will be completed based on QAPI recommendations. 05/08/2023 Random weekly medication audits will be done on all OTC medications to ensure they are labeled appropriately until improvement is noted. Further audits will be completed based on QAPI recommendations. All audits will be monitored through QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**05/03/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/03/2023. At the time of this survey, Mahnomen Health Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers.The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/23/2023

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.

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K 000	Continued From page 1 National Fire Alarm Code." The facility has a capacity of 32 beds and had a census of 29 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.	K 000		

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	00353	A. BUILDING: _____ B. WING _____	C 05/03/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/1/23 through 5/3/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed, with no licensing orders issued: H52381766C (MN90331) H52381714C (MN92999) H52381786C (MN84150) H5238041C (MN82984) H5238042C (MN76722) H5238043C (MN74288) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		5/19/23

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21545	Continued From page 3 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication error rates were 5 percent or less for 3 of 11 residents (R4, R18, R26) observed during medication administration. Findings include: R4's physician order dated 3/8/23, inlcuded calcium carbonate-vitamin D3 600 mg-200 international units (iu) tablets. Take one tablet by mouth twice a day. During observation on 5/1/23 at 7:02 p.m., registered nurse (RN)-A administered one tablet of calcium-vitamin D3 600 mg - 400 iu to R4.	21545	Corrected	

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21545	Continued From page 4 During an interview on 5/3/23 at 9:41 a.m., licensed practical nurse (LPN)-A stated the medication dosage on the bottle and provider prescribed dosage did not match. Because of this, the physician should have been contacted. During an interview on 5/3/23 at 9:42 a.m., LPN-B stated R4's calcium with vitamin D order was the same order since 2019. The order was recently reviewed and signed by primary care provider (PCP)-A on 3/8/23. Anytime a medication dosage and physician's order does not match, staff would need to contact the PCP. During a telephone interview on 5/3/23 at 9:44 a.m., pharmacist (P)-A stated the pharmacy records identified RN-B called in the order for calcium carbonate - vitamin D3 600 mg - 400 iu one tab by mouth twice a day on 7/20/22, . P-A stated the medication dose was not equivalent to the medication ordered. R18's physician order dated 6/30/22, identified to discontinue timolol ophthalmic eye drop (focused to treat open-angle glaucoma and other causes of high pressure inside the eye) in left eye and continue latanoprost eye drop (treat high pressure inside the eye due to glaucoma [open angle type] or other eye diseases such as ocular hypertension, ophthalmic-intraocular pressure reducing agents, prostaglandin analogs) in both eyes at bedtime. During observation on 5/2/23 at 4:04 p.m., LPN-C administered timolol 0.5% one drop to the left eye. During a telephone interview on 5/3/23 at 12:02 p.m., LPN-C stated the process for ordering medications was done electronically. The	21545		

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21545	Continued From page 5 medication was received from the pharmacy in a locked bag with a packing slip for the nurse to check off medications received. If LPN-C was unsure of a correct medication, she could use her phone or drug book to verify the correct medication. Further, timolol eye drops and latanoprost eye drops were not the same. LPN-C shouldn't have given the timolol eye drop because it was discontinued. The nurse should have double checked the order and called the pharmacy for the correct medication when the medication was received. During interview on 5/3/23 at 1:34 p.m., director of nursing (DON) stated sometimes the physician discontinues a medication at the nursing home and forgets to take it off clinic chart and the pharmacy continues to refill the prescription. R26's physician order dated 4/18/23, included citrus calcium-vitamin D3 200 mg -250 iu tablets. Take one tablet by mouth twice a day. During observation on 5/1/23 at 6:11 p.m., RN-A administered calcium-vitamin D 600 mg-400 iu one tab by mouth to R26. During interview on 5/3/23 at 8:36 a.m., LPN-A stated family brought in an over-the-counter bottle of calcium with vitamin D. The bottle's manufacturer label identified each tablet contained calcium-vitamin D 600 mg -400 iu. Further, the dosage on the manufacturer label did not match the physician's order. During an interview on 5/3/23 at 9:38 a.m., LPN-B stated family brought in the over-the-counter bottle of calcium with vitamin D for R26. The medication should have been verified against the physician's order prior to use. If the medication	21545		

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21545	Continued From page 6 dosage was not correct, nursing should contact the physician for guidance. During a telephone interview on 5/3/23 at 9:47 a.m., P-A stated the pharmacy had not delivered calcium-vitamin D 600 mg -400 iu for R26. The medication dose given was not equivalent to the medication ordered. During a telephone interview on 5/3/23 at 1:45 p.m., PCP-A stated staff should reach out to him with any medication discrepancies to prevent a medication error. During an interview on 5/3/23 at 2:39 p.m., DON stated staff should perform the five rights of medication administration (the right dose, the right medication, the right resident, the right route and the right time) to reduce medication errors. Staff should utilize resources such as the physician, the pharmacy and/or online drug references if there are discrepancies. The policy Medication and Treatment Administration dated 2023, identified when drugs were administered, staff should verify the correct resident, medication, time, route and dose by referring to the medication administration record (MAR). SUGGESTED METHOD OF CORRECTION: The DON or designee could review/revise policies/procedures for medication administration, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21545		