Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 3, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: August 3, 2023

Dear Administrator:

On August 3, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 3, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

Re: Reinspection Results
Event ID: OJPS12

Dear Administrator:

On August 3, 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 June 22, 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
July 12, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

RE: CCN: 245422
Cycle Start Date: June 22, 2023

Dear Administrator:

On June 22, 2023, a survey was completed at your facility by the Minnesota Department of Health 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 September 22, 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 December 22, 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.

Feel free to contact me if you have questions.

Sincerely,

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
	245422	A. BUILDING ______ B. WING ______	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CENTER	730 SECOND STREET SOUTHEAST MILACA, MN 56353

(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
F 000	INITIAL COMMENTS On 6/21/23 to 6/22/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H54222946C (MN00094540) with deficiencies issued at F602 and F755 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. 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 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure a	F 602	This Plan of Correction constitutes my written allegation of compliance for the	8/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/19/2023

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.

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F 602	Continued From page 1 system to safeguard narcotic medication for 1 of 3 residents (R1) reviewed, and whose narcotic medication was diverted by 1 of 1 registered nurse (RN-A) for personal use. Findings include: R1's face sheet showed an admission date of 5/23/23, for aftercare following left foot amputation. R1's care plan identified pain as a problem and the approaches included administration of pain medications as ordered. R1's medications included an order dated 5/24/23, for oxycodone 5 mg (milligram) 1 tablet by mouth every 4 hours as needed for severe pain. R1's medication administration history record indicated that R1 had not received any oxycodone 5 mg tablet from 5/24/23, until it was discontinued on 6/15/23. During interview on 6/21/23 at 10:19 a.m., licensed practical nurse (LPN)-A explained that two staff nurses count narcotics at the end of each shift, by the off-going and in-coming staff. LPN-A stated that one nurse holds the narcotic book, reads the non-highlighted lines (with page #) in the index (contents page), and then flips through the sheets to look for the actual page indicated or with corresponding page # while the other nurse looks for the identified stock medication in the narcotic lockbox/drawer. LPN-A stated, she would not search for an actual sheet/page in the narcotic book if the line with that page was highlighted in the index. LPN-A stated there had been no issues in a long time but within the last two weeks, administration sent a reminder "to make sure we're keeping up with the books and the meds [medications] on hand" and to make sure all medications in the pages	F 602	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia (Milaca Elim Meadows Health Care Center) to comply with (F602) To assure continued compliance, the following plan is now in place: Regarding cited resident: R1 the facility failed to ensure a system to safeguard narcotic medication for 1 of 3 residents (R1) reviewed, and whose narcotic medication was diverted by 1 of 1 registered nurse for personal use. An investigation was completed, vulnerable report filed, and the police notified on June 16 2023. Actions taken to identify other potential residents having similar occurrences: All current residents narcotic medications were reviewed to ensure no other diversion had taken place. Measures put in place to ensure deficient practice does not recur: Medication management policy & procedure reviewed and no changes were made. Licensed staff, Health unit coordinators and Trained Medication Assistance were	

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F 602

Continued From page 2
have end dates.

During interview and observation on 6/21/23 at 10:26 a.m., LPN-B stated that two nurses do narcotic counts every staff turnover. LPN-B brought out a narcotic book and demonstrated the narcotic count showing that nurses would pay attention to the information (page #, name of resident, name of medication) on what was not "yellowed-out" in the index and then look for the actual page, which contain a "sticker" that should match the information. LPN-B stated that the second nurse would look for the identified medication in the narcotic lockbox/drawer. LPN-B also stated that if a medication was discontinued for any reason, it would be "yellowed-out" or highlighted in the index and the actual page would be crossed-out to indicate that it was no longer active, and staff would not pay attention to lines/pages that were highlighted.

During interview on 6/21/23 at 11:19 a.m., RN-B stated that during shift change on 6/14/23, she and another nurse were counting the narcotics on the West Unit medication cart and discovered that R1's medication card with 24 oxycodone 5 milligram (mg) tablets was not in the narcotic lockbox. RN-B stated that during the counting process, she was holding the narcotic book and read the actual sheet for page 61 that showed R1's oxycodone 5 mg with 24 tablets in stock, which was not crossed out, indicating the medication order was still active. RN-B stated that she read aloud page 61 for the other nurse to look for the medication in the lockbox, however, it was not there. RN-B stated they then observed that page 61 was highlighted in the index but there was no end date noted. RN-B also stated that they "searched everywhere" but could not

F 602

educated on medication diversion and the policy and procedure of counting narcotics and shift change 7/27/23 and 8/2/23. Licensed staff, Health unit coordinators and trained medication assistants were educated on Narcotic management, proper documentation and forms for residents whose medications are sent home upon discharge.

Effective implementation of actions will be monitored by:
The clinical managers will audit Narcotic books and lock boxes weekly X 4 weeks and then monthly X 2 months to ensure that narcotic counts match the card and the narcotic record book. The facility QAPI committee will review results of these audits and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of nursing or designee is responsible for maintain compliance.

Completion date for certification purposes only is: August 2nd 2023

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find the medication. RN-B described that the usual practice was for staff to see the page # on the non-highlighted lines in the index and go straight to the actual page, and they also used paper clips to stick the book's "used" pages together. RN-B further stated they would not have checked/opened the narcotic book onto page 61 because it was already highlighted in the index (inactive), however, she happened to notice the actual sheet for page 61 because the paper clip that held page 61 together with the other "used" sheets/pages, fell off. RN-B added, she had to read page 61 because it was not crossed out, and that prompted the search where they discovered that the medication was missing.

During interview on 6/21/23 at 8:59 a.m., the director of social services (DSS), stated having learned about the drug diversion incident on 6/15/23. The DSS stated she immediately investigated by looking at the cameras where "a pool nurse unlocked the narc [narcotic] med [medication] cart, took the med card out, and put it under her clip board on top of the med cart, then continued standing there and as if doing something, then she took the clipboard and the med card, walked around, and put it in a bag at the nurses' station. She talked to the NAs [nursing assistants], and when the NAs left, she took the bag and went to the rest room and stayed there for about 26 minutes and then came out."

During interview on 6/21/23 at 12:52 p.m., the assistant director of nursing (ADON) stated that their system had been working before, where the nurses would highlight the meds that had been used up/discontinued/destroyed from the index and "paper clip" the used pages. The used pages

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F 602 Continued From page 4 F 602

in the narcotic book would be crossed out to also indicate it was no longer in use. The ADON also stated that the facility's system still did not fail because their staff discovered the missing medication, discovered who did it, and did the necessary reports. The ADON characterized the staff who diverted the drug as "a criminal and smart" and further stated that "if she only had crossed page 61 out, then it wouldn't have been caught." (Identifying a fault in the facility's current system).

During interview on 6/22/23 at 9:17 a.m., RN-C stated, "What we do when we count is one nurse will count the meds in the lockbox and the other nurse will check the book, go to the page number written in the med card." RN-C added that if the medications were not in the cart, they would not look for the page in the book. RN-C stated that she received an email from the ADON sent on 6/20/23, but that she had "not read through it personally" and was unsure if there were any recent changes in the process of narcotic counting. RN-C then opened computer to read her email, and stated the reminders included how to identify drug diversion, and when counting narcotics, the person with the book should lead the counting. RN-C acknowledged that drug diversion could still happen because the one holding the book would only focus on reading the non-highlighted lines and would not be looking for the actual page if the line for that page was already highlighted in the index, and that if the narcotic was not in the lockbox, it would not be known.

During interview on 6/22/23 at 9:26 a.m., LPN-D stated that she was taught that narcotic counting was to be done at the end of each shift by the

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oncoming and leaving staff. LPN-D stated when she was oncoming, she counts the actual medications and when she is leaving, she holds the book and leads the counting. LPN-D stated that has been the process since she started in 2013. LPN-D explained that if the line identifying the page number, resident's name, and medication, was highlighted in the index, they won't be looking for the actual page where the remaining amount for that medication would be documented. LPN-D acknowledged the possibility to miss accounting for narcotics if they were already taken out from the narcotic lockbox and had been highlighted in the index and crossed out in the corresponding actual page. LPN-D further stated she did not know a better alternative.

During interview on 6/22/23 at 9:51 a.m., the director of nursing (DON) acknowledged that the facility's practice for narcotic counting "did not change much" even after the drug diversion incident. The DON stated that the education sent out to staff was "kind of a reminder" of the same process that has been in place for a long time. The DON stated, "I don't know what would be a different way" and further stated the facility would consult a corporate nurse if there was a different system that other facility's have.

During observations with the facility's camera recorded video on 6/22/23 at 10:21 a.m., a female person opened a medication cart, took out what looked like a medication card (bubble pack), and put it under a clip board on top of medication cart. There were 2 other female individuals who showed up, they talked to the female on the med cart, and they left. The female on the medication cart took the clip board including what she put underneath and walked around towards the

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nurses' station, where she was bending to a bag. She carried the bag on her shoulders and walked towards what the DSS said as the location of a public restroom.

The facility's narcotic register showed in the index, a highlighted line for page 61 (R1's name, the prescribing physician's name, oxycodone 5 mg, prescription number, and 5/24/23 as start date), which indicated it was no longer active, even though, it did not indicate an end date. The corresponding sign out sheet for page 61 documented R1's oxycodone 5 mg tablet with the quantity received as 24, and R1 did not use any.

A review of the local police department's incident report, dated 6/15/23 and modified on 6/16/23, indicated that on 6/15/23, a police officer summoned RN-A to show up at the police department for a statement regarding the allegation of narcotic theft. The report also indicated that on 6/16/23 at 9:50 a.m., RN-A appeared at the police department and readily confessed to the police officer that she did take R1's narcotics.

The facility's policy titled, Medication Management, dated 7/16/18 and reviewed on 2/20/23 with a subtitle Narcotic Count, indicated after verifying the correct amount of controlled substances delivered, apply the second "voided" label for that medication to the bound narcotic register; log the controlled medication in the front index of the bound narcotic register on the numbered line corresponding to the page on which the medication was entered; and the date, time, dose, nurse's signature and quantity remaining are entered in the bound narcotic register with each dose given. The policy also

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F 602	Continued From page 7 indicated that controlled substances or narcotics are counted at the end of each shift; the count is done by having 1 nurse look at the index and corresponding sign out page; a 2nd nurse confirms the quantity remaining in the corresponding medication card, box or bottle; and if a medication is missing or cannot be accounted for, notify director of nursing immediately (or designee) who will determine the appropriate course of action. The facility's document titled, Drug Diversion Re-education - Facility Narcotic Management, dated 6/16/23, reiterated the following: all medications in the narcotic book are entered in the front ledger and the corresponding page with all the required information; when a page is no longer active for any reason other than reaching 0 (zero), there will be a corresponding note with the licensed employees initials on the bottom of the page and follow instructions (i.e. moved to page #); anytime medication is removed the page will be crossed off in the front ledger with a highlighter and the date of removal or D/C (discontinuation) will be transcribed in the last column of the ledger; the actual page will have a line through it with the initials of the nurse; counts will be performed by the oncoming nurse who will read the mediation cards while the off going nurse leads the counting and reads the book by looking at the front ledger and then find the corresponding page.	F 602		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		8/2/23

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F 755	Continued From page 8 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and records review, the facility did not ensure safe disposition of controlled substances for 2 of 3 residents (R2 and R3) reviewed for medication management, for not documenting medication disposal and not pulling out discontinued medication from stock and updating the records. Findings include:	F 755	Regarding cited resident: R2 It was verified that family picked up medications from the facility upon discharge from the hospital. R3 discontinued tramadol was pulled from lock box on 6/21/23 and destroyed per policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245422	A. BUILDING ______ B. WING ______	C 06/22/2023

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F 755	Continued From page 9 Documentation of medication disposal R2's minimum data set (MDS) history showed an admission date of 12/12/22, with a corresponding discharge date of 4/20/22. The MDS indicated primary diagnoses of fractures and other multiple traumas. The medication orders for R2 included tramadol 50 mg (milligram) by mouth for moderate to severe pain, with a start date of 2/14/23 and discontinued on 4/20/23. The facility's narcotic register showed on page 22 of the index that R2's supply of tramadol 50 mg tablet started on 4/4/23 and ended on 4/24/23. However, the corresponding actual page 22 was not crossed out, showing 30 tablets of tramadol 50 mg remaining. R2's medication administration record also showed that R2 did not receive any tramadol from 4/4/23 to 4/24/23. During interview on 6/21/23 at 10:26 a.m., licensed practical nurse (LPN) B verified that the narcotic register showed a stock of 30 tablets for R2's tramadol 50 mg, however, the medication was not in the narcotic lockbox. During interview on 6/21/23 at 11:54 a.m., the director of nursing (DON) verified that there was no stock for R2's tramadol 50 mg medications in the medication cart, and although page 22 was highlighted in the index of the narcotic register, the actual page 22 showed a remaining amount of 30 tablets. The DON stated the process whenever a medication went into destruction, sent home, or returned to pharmacy, it should be documented. The DON verified that there was lack of documentation to show where R2's tramadol 50 mg was disposed.	F 755	Actions taken to identify other potential residents having similar occurrences: Contents of lock boxes was reviewed to ensure no discontinued medications were present. A review of residents who were discharged in the last 90 days from 6/21/23 were reviewed to identify any other potential resident with the similar occurrence of no documentation. Measures put in place to ensure deficient practice does not recur: Licensed staff, Health unit coordinators and Trained Medication Assistance were educated on 7/27/23 and 8/2/23 medication diversion and the policy and procedure of counting narcotics and shift change. Licensed staff, Health unit coordinators and trained medication assistants were educated on Narcotic management, proper documentation and forms for residents whose medications are sent home upon discharge. The Consulting pharmacist was here on July 13, 2023 for the facility quarterly visit and will continue to visit the facility on quarterly bases to fulfill contractual obligations. Effective implementation of actions will be monitored by: The clinical managers will audit Narcotic books and lock boxes weekly X 4 weeks and then monthly X 2 months to ensure that narcotic counts match the card and the narcotic record book. The facility	

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F 755	Continued From page 10 During interview on 6/21/23 at 1:36 PM the DON, assistant director of nursing (ADON) and Unit Coordinator (UC)-A verified that the facility discharged R2 to the hospital on 4/20/23. They also verified the discharging nurse did not document anything about medication disposal and that there was no record to show an inventory of what family members took out when they came to pick up R2's belongings when R2 decided to go home instead of returning to facility. During interview on 6/21/23 at 3:50 p.m., UC-A stated she had called R2's family member (FM)-A, who informed UC-A that FM-B picked up R2's belongings including the medications from the facility. During interview on 6/21/23 at 3:45 p.m., LPN C verified she was the nurse on duty on 4/24/23, when R2's family member came in to pick up R2's belongings. LPN-C stated that UC-B "okayed" to release the narcotics. LPN-C stated handing the medications to FM-B. LPN-C also stated she could not remember if she documented about the medication disposal saying, "It was a long time ago in April." During interview on 6/22/23 at 7:52 a.m., FM-B stated taking R2's belongings home including tramadol which was to be given to R2 "as needed." During follow-up interview on 6/22/23 at 9:51 a.m., the DON acknowledged that staff did not follow facility protocol for R2's medication disposal. The DON stated it was human error that it was missed. Pulling out discontinued medication	F 755	QAPI committee will review results of these audits and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of nursing or designee is responsible for maintain compliance. Completion date for certification purposes only is: August 2nd 2023	

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F 755	Continued From page 11	F 755		

R3's face sheet showed an admission date of 5/12/23 for orthopedic aftercare following surgical amputation. The medication orders for R3 included tramadol 50 mg by mouth every 6 hours as needed for moderate to severe pain with a start date of 5/16/23 and an end date of 5/22/23.

The facility's narcotic register showed in the index that page 55 contained R3's tramadol 50 mg with a start date of 5/16/23 but with no end date.

During observation on 6/21/23 at 10:26 a.m., R3's tramadol 50 mg (8 tablets) were still in stock at the west unit's narcotic lockbox. LPN-B verified that R3 did not take any of the tramadol since order date of 5/16/23. LPN B also verified that the medication was discontinued on 5/22/23 but the medications remain in the narcotic lockbox.

During interview on 6/22/23 at 9:51 a.m., the DON stated that the ADON and the UC-A did an inventory of all the carts after the drug diversion incident but the DON did not say anything about R3's discontinued medication that remained in stock after the audit. The DON stated, "What I can say is that when the med was discontinued [LPN A] was training a new nurse, and the new nurse was working on the cart, and it was missed." The DON acknowledged that staff did not follow medication management policy for R3's tramadol and stated they did not get back to the cart to pull out the medication and update the narcotic register.

On 6/22/23 at 12:26 p.m., attempted a call to the pharmacy consultant for interview but did not receive a return call.

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F 755	Continued From page 12 The facility provided a document titled, Policy and Procedure Manual, Version 2.0, 08.27.19, subtitled, Consultant Pharmacist Services Duties, which directed the consultant pharmacist to check the medication storage rooms, and medication carts for proper storage of medications, and submitting a written report and recommendation; and assisting in the accounting, destruction, and reconciliation of unused controlled and noncontrolled substances as requested. The facility's Medication Management policy with latest review date of 2/20/23, subtitled, Narcotic Count, indicated that narcotics will be counted at the end of each shift. The policy also indicated that when a resident is discharged with orders for controlled substances staff should obtain a physician's order with ok to discharge resident with each specific controlled substance. The policy's subtitled Medication Disposition indicated that as soon as practicable after discontinuance, death or discharge the following should occur: a) Complete medication disposition form indicating the prescription number and quantity of each medication and indicating whether it was sent home with resident or is being sent to the DON for destruction; b) Complete information in the bound narcotic ledger indicating that the medication has been removed for destruction. This documentation is to be co-signed by the DON (designee) upon removal of the medication from the medication cart; c) Complete the information in the index at the front of the bound narcotic ledger that the medication has been removed and yellow-out that line in the index; DON (or designee) will complete the certificate and inventory destruction form. This form will be double checked against medications being	F 755		

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F 755	Continued From page 13 destroyed by second nurse during the destruction process.	F 755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 12, 2023

Administrator
Milaca Elim Meadows Health Care Center
730 Second Street Southeast
Milaca, MN 56353

Re: State Nursing Home Licensing Orders
Event ID: OJPS11

Dear Administrator:

The above facility was surveyed on June 21, 2023 through June 22, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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2 000	Initial Comments	2 000		

*****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 6/21/23 to 6/22/23, a complaint 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 licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

Minnesota Department of Health

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaint was reviewed.
H54222946C (MN00094540) with a licensing order issued at 1525

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 surveyor's 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 14-01, available at 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 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of

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2 000	Continued From page 2 state form. 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.	2 000		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observations, interviews, and records review, the facility did not ensure safe disposition of controlled substances for 2 of 3 residents (R2 and R3) reviewed for medication management, for not documenting medication disposal and not pulling out discontinued medication from stock and updating the records. Findings include: Documentation of medication disposal	21525	Corrected.	8/2/23

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21525	Continued From page 3	21525		

R2's minimum data set (MDS) history showed an admission date of 12/12/22, with a corresponding discharge date of 4/20/22. The MDS indicated primary diagnoses of fractures and other multiple traumas. The medication orders for R2 included tramadol 50 mg (milligram) by mouth for moderate to severe pain, with a start date of 2/14/23 and discontinued on 4/20/23.

The facility's narcotic register showed on page 22 of the index that R2's supply of tramadol 50 mg tablet started on 4/4/23 and ended on 4/24/23. However, the corresponding actual page 22 was not crossed out, showing 30 tablets of tramadol 50 mg remaining. R2's medication administration record also showed that R2 did not receive any tramadol from 4/4/23 to 4/24/23.

During interview on 6/21/23 at 10:26 a.m., licensed practical nurse (LPN) B verified that the narcotic register showed a stock of 30 tablets for R2's tramadol 50 mg, however, the medication was not in the narcotic lockbox.
During interview on 6/21/23 at 11:54 a.m., the director of nursing (DON) verified that there was no stock for R2's tramadol 50 mg medications in the medication cart, and although page 22 was highlighted in the index of the narcotic register, the actual page 22 showed a remaining amount of 30 tablets. The DON stated the process whenever a medication went into destruction, sent home, or returned to pharmacy, it should be documented. The DON verified that there was lack of documentation to show where R2's tramadol 50 mg was disposed.

During interview on 6/21/23 at 1:36 PM the DON, assistant director of nursing (ADON) and Unit Coordinator (UC)-A verified that the facility discharged R2 to the hospital on 4/20/23. They

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21525	Continued From page 4	21525		

also verified the discharging nurse did not document anything about medication disposal and that there was no record to show an inventory of what family members took out when they came to pick up R2's belongings when R2 decided to go home instead of returning to facility.

During interview on 6/21/23 at 3:50 p.m., UC-A stated she had called R2's family member (FM)-A, who informed UC-A that FM-B picked up R2's belongings including the medications from the facility.

During interview on 6/21/23 at 3:45 p.m., LPN C verified she was the nurse on duty on 4/24/23, when R2's family member came in to pick up R2's belongings. LPN-C stated that UC-B "okayed" to release the narcotics. LPN-C stated handing the medications to FM-B. LPN-C also stated she could not remember if she documented about the medication disposal saying, "It was a long time ago in April."

During interview on 6/22/23 at 7:52 a.m., FM-B stated taking R2's belongings home including tramadol which was to be given to R2 "as needed."

During follow-up interview on 6/22/23 at 9:51 a.m., the DON acknowledged that staff did not follow facility protocol for R2's medication disposal. The DON stated it was human error that it was missed.

Pulling out discontinued medication

R3's face sheet showed an admission date of 5/12/23 for orthopedic aftercare following surgical amputation. The medication orders for R3 included tramadol 50 mg by mouth every 6 hours

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21525	Continued From page 5	21525		

Continued From page 5

as needed for moderate to severe pain with a start date of 5/16/23 and an end date of 5/22/23.

The facility's narcotic register showed in the index that page 55 contained R3's tramadol 50 mg with a start date of 5/16/23 but with no end date.

During observation on 6/21/23 at 10:26 a.m., R3's tramadol 50 mg (8 tablets) were still in stock at the west unit's narcotic lockbox. LPN-B verified that R3 did not take any of the tramadol since order date of 5/16/23. LPN B also verified that the medication was discontinued on 5/22/23 but the medications remain in the narcotic lockbox.

During interview on 6/22/23 at 9:51 a.m., the DON stated that the ADON and the UC-A did an inventory of all the carts after the drug diversion incident but the DON did not say anything about R3's discontinued medication that remained in stock after the audit. The DON stated, "What I can say is that when the med was discontinued [LPN A] was training a new nurse, and the new nurse was working on the cart, and it was missed." The DON acknowledged that staff did not follow medication management policy for R3's tramadol and stated they did not get back to the cart to pull out the medication and update the narcotic register.

On 6/22/23 at 12:26 p.m., attempted a call to the pharmacy consultant for interview but did not receive a return call.

The facility provided a document titled, Policy and Procedure Manual, Version 2.0, 08.27.19, subtitled, Consultant Pharmacist Services Duties, which directed the consultant pharmacist to check the medication storage rooms, and medication carts for proper storage of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00376	A. BUILDING: ___ B. WING ___	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILACA ELIM MEADOWS HEALTH CARE CEN	**730 SECOND STREET SOUTHEAST MILACA, MN 56353**

(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) COMPLETE DATE
21525	Continued From page 6	21525		

medications, and submitting a written report and recommendation; and assisting in the accounting, destruction, and reconciliation of unused controlled and noncontrolled substances as requested.

The facility's Medication Management policy with latest review date of 2/20/23, subtitled, Narcotic Count, indicated that narcotics will be counted at the end of each shift. The policy also indicated that when a resident is discharged with orders for controlled substances staff should obtain a physician's order with ok to discharge resident with each specific controlled substance. The policy's subtitled Medication Disposition indicated that as soon as practicable after discontinuance, death or discharge the following should occur: a) Complete medication disposition form indicating the prescription number and quantity of each medication and indicating whether it was sent home with resident or is being sent to the DON for destruction; b) Complete information in the bound narcotic ledger indicating that the medication has been removed for destruction. This documentation is to be co-signed by the DON (designee) upon removal of the medication from the medication cart; c) Complete the information in the index at the front of the bound narcotic ledger that the medication has been removed and yellow-out that line in the index; DON (or designee) will complete the certificate and inventory destruction form. This form will be double checked against medications being destroyed by second nurse during the destruction process.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to disposition of controlled substances,

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documentation of medication disposal and pulling of discontinued medication from stock. The DON or designee could educate staff to ensure procedures are implemented. The DON or designee should review processes to ensure the pharmacist begins or maintains appropriate oversight of the disposition process. The DON or designee could have a methodical system to verify compliance, such as auditing medication carts and or medical records for specific amount of days x___, then weekly x ___, then monthly x___, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.