Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 19, 2023

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
Cycle Start Date: June 14, 2023

Dear Administrator:

On July 11, 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2023

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

RE: CCN: 245453
Cycle Start Date: June 14, 2023

Dear Administrator:

On June 14, 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 14, 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 14, 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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June 20, 2023

Administrator
Lb Broen Home
824 South Sheridan
Fergus Falls, MN 56537

Re: Event ID: 69QG11

Dear Administrator:

The above facility survey was completed on June 14, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245453	A. BUILDING _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LB BROEN HOME	824 SOUTH SHERIDAN FERGUS FALLS, MN 56537

(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 6/13/23 and 6/14/23, 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 complaints were reviewed. H54532695C (MN00094223) and H54531820C (MN00093004) As a result of the investigation, F610 and F755 were cited. 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		7/10/23

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

Electronically Signed | 06/29/2023

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 610	Continued From page 1 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed thoroughly investigate and take corrective action to prevent recurrence of a significant medication for 2 of 2 residents (R1, R2) reviewed for medication administration. Findings include: R1's Diagnoses Report dated 5/31/23, identified diagnoses pyogenic arthritis (painful infection in a joint). R1's Order Summary Report dated 6/6/23, identified: -5/31/23, Vancomycin intravenous (IV) solution 750 milligrams (mg)/150 milliliters (ml) use 1 vial IV every 18 hours for left should septic arthritis until 6/23/23, at 11:59 p.m. Flush using SASH method Saline, antibiotic, saline, heparin. -6/5/23, Vancomycin IV solution 1250 mg IV one time a day for septic arthritis until 6/23/23 at 11:59 p.m. Review of Incident Report submitted to the Minnesota Department of Health (MDH) on 6/5/23 at 4:31 p.m., identified an incident occurred on	F 610	F610 R1 was discharged from the facility 06/07/2023 R2 was discharged from the facility 05/21/2023 All residents receiving medication in the facility have the potential for a significant medication error based on guidance stating: the relative significance of medication errors is a matter of professional judgment and is based on three general guidelines resident condition, drug category, and frequency of error. The facility failed to thoroughly investigate and take corrective action to prevent recurrence of a significant medication error. Multiple forms and policies and procedures, as noted below, were updated to provide more specific reminders to the DON or substitute to assure all staff authorized to administer medications are re-educated following medication errors. The following documents were updated to reflect this system change:	

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F 610	Continued From page 2 6/1/23 at 3:30 a.m. The report indicated from 6/1/23 to 6/4/23, an order for Vancomycin 750 mg every 18 hours on electronic medical record (EMAR), label on Vancomycin read 1.25 mg every 24 hours. R1 had been receiving 1.25 mg every 18 hours. Review of Incident Investigation form dated 6/9/23 at 10:59 a.m., included the following information: IV orders were received on 5/30/23, resident was admitted on 5/31/23. Medication arrived from outside pharmacy on 5/31/23. Order on EMAR was for Vancomycin 750 mg every 18 hours. Order on medication label was 1.25 gm every 24 hours. 6/1/23 through 6/4/23, resident received 1.25 mg every 18 ours. On 6/5/23, upon discovery of the order discrepancy pharmacy was contacted. On 5/31/23 orders had been received by pharmacy from hospital to change the order to 1.25 mg every 24 hours. "This was not communicated to nursing home." As part of correction, on 6/5/23 facility received fax orders reflecting change from pharmacy and order was corrected on EMAR. Review of an Incident Investigation form dated 6/9/23, action taken to prevent reoccurrence to other residents will now have IV medication double checked by two licensed staff prior to administration. Similar incidents that have occurred in the past six months: had an incident about one month ago where a resident was receiving IV Vancomycin and IV Cefepime twice a day (bid) and the resident received two doses of Vancomycin in one day instead of the Cefepime. Facility lacked evidence corrective action identified indicated in investigation form dated 6/9/23 was implemented. Additionally, no nursing	F 610	Medication/Treatment Error Policy and Procedure was revised to include a second purpose: □To prevent recurrence of similar medication/treatments errors. Further direction to the DON or designated substitute was also added to item 3f. to read □Evaluate each error and recommend systems changes and assign educational interventions to prevent recurrence as indicated.□ BMH #1009-96, Medication/Treatment Error Report, was revised adding □what education was provided and who will receive it□ to the current □Describe plan identified to prevent future, similar errors.□ This serves as a reminder that education following medication errors must be completed to prevent future similar errors and documents the assigned re-education. All staff identified in the Medication Administration, Authorized Staff Policy and Procedure, dated March 2023, will be assigned education following medication/treatment errors as assigned by the DON or substitute on-going. BH #1010-92, Medication/Treatment Error Log, was revised to include an additional column titled □Education provided Y/N□. This serves as a check and reminder that education following the medication/treatment error was assigned. This log is completed by the DON or ADON. New form: BH: #848-23,	

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F 610	Continued From page 3 staff were re-educated to identify discrepancies during medication administration to prevent re-occurrence. R2's Order Summary Report dated 6/6/23, identified: methicillin resistant staphylococcus aureus infection (MRSA) (staph infection difficult to treat due to resistance against some antibiotics) and infection of implanted electronic neurostimulator of the spinal cord. . R2's Order Summary Reported dated 5/11/23, identified: -4/18/23, Cefepime IV solution 2 grams (gm) two times a day for sepsis (every 12 hours). -4/24/23, Cefepime IV solution 2 gm two times a day for sepsis until 4/26/23 at 10:59 a.m., Flush using SASH method with each use. -Vancomycin IV use 1000 mg one time a day IV for sepsis (every 24 hours). -Vancomycin IV solution use 1000 mg IV one time a day for sepsis until 4/25/23 at 11:59 p.m. (every 24 hours). Review of an Incident Report submitted to the Minnesota Department of Health (MDH) on 4/24/23 at 11:26 a.m., identified an incident occurred on 4/23/23 at 12:00 a.m. The report indicated resident received two doses of IV Vancomycin in one day. Order was for Vancomycin daily and Cefepime twice a day. Review of Incident Investigation form dated 4/28/23 at 11:09 a.m., indicated action taken to prevent reoccurrence to other residents was to have all registered nurses who administered the IV medication to complete an audit for administration of oral medications, since there	F 610	Medication/Treatment Error Education Review Audit, was created to require the facility to monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. This audit was added to the quarterly nursing audit system within the facility. Corrective actions identified in the 6/09/2023 Incident Investigation form regarding the IV Vancomycin error have been implemented and staff education will be provided. A system change was implemented requiring two staff authorized to administer medication to verify IV orders prior to administration to assure correct medication, dose, route, time, and form prior to administration. Additionally, both staff verifying the medication are now required to sign on the resident□s Point Click Care EMAR prior to administration. The following documents were updated to reflect this system change: BH #1356-21, Master Transcription of Orders, Medication, Start of was revised to include requiring two staff, authorized to administer medication, to verify the original provider order, eMAR/order transcription, and the RX label all match. Additionally, both staff verifying the medication are now required to sign on the resident□s Point Click Care EMAR prior to administration. BH #844-23, LB Broen Home Medication Administration: Checklist for Administration of IV Medications was	

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F 610	Continued From page 4 were no residents in facility at this time receiving IV medication, with particular attention being paid to checking the medication label against the medicine list on the EMAR. During an interview on 6/13/23 at 2:30 p.m., registered nurse (RN)-A stated the facility medication administration policy was reviewed and a change was to be made to include two staff required to double check the rights of medication administration prior to the IV medication to be given. RN-A verified medication administration education, audits, and competencies had not been completed. During an interview on 6/13/23 at 3:30 p.m., RN-B stated unaware of any changes made or education provided staff in the past three months to avoid further IV medication errors. During an interview on 6/13/23 at 4:20 p.m., RN-C stated Educare was required to be completed throughout the year on the computer, but IV medications are not included. RN-C also stated had not heard anything about or completed IV medication administration education, audits, or a competency to be completed with another staff. During an interview on 6/14/23 at 10:54 a.m., assistant director of nursing (ADON) stated she had planned on making a change and update to the medication policy to read two staff needed to verify the IV medication prior to administration. ADON verified this had not been implemented yet. ADON indicated she had a medication administration checklist available, planned on completing audits with the nurses involved in both incidents but never got that completed. ADON also stated a refresher on rights of medication	F 610	created. The checklist includes verification of the original provider order, the eMAR/order transcription, and the RX label all match. Additionally, any discrepancies must be clarified with the ordering provider prior to administration. This checklist has been added to the LB Broen Home Competency Training: RN □ IV Therapy and NG Technique. A staff meeting will be held 07/05/2023, for all staff authorized to administer medications. A review of all noted new and revised forms and policies and procedures will be completed by the DON and ADON. Changes to IV medication administration requiring verification of the dose by two staff authorized to administer medications prior to administration and of the requirement for two signatures in the eMAR will be reviewed. Specific emphasis will be placed on the importance of verifying the original provider order, the eMAR/order transcription, and the RX label all match and that any discrepancies must be clarified with the ordering provider prior to administration. All staff trained to transcribe Physician□s Orders will be educated on the update to the Master Transcription of Orders, Medication, Start of revisions in Point Click Care. The DON, ADON, and RN Unit Coordinators were re-educated on assuring each medication/treatment error results in a corrective action to prevent the recurrence of medication/treatment errors.	

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F 610	Continued From page 5 administration with those licensed nursing staff involved would have been important to assure things were completed, so no resident was harmed. ADON indicated a one-to-one competency regarding medication administration was planned to be completed among licensed staff to observe each other but had also not been implemented yet. During an interview on 6/14/23 at 3:30 p.m., director of nursing (DON) verified medication administration education had not been given to staff yet after R1 or R2's incident. Review of a facility policy titled Medication Administration and Disposal dated 1/2023, identified to ensure safe, accurate medication administration to residents authorized personnel are expected to follow appropriate standards and protocols including the seven rights of medication administration: right patient, medication, dose, time, route, documentation, and refusal. Requested IV medication administration policy and was not received.	F 610	The Checklist for Administration of IV Medications, BH #844-23, has been assigned to all staff authorized to administer medications for completion. A verbal review of the checklist will be completed, as there are currently no IV medications ordered in the facility. The Medication/Treatment Error Education Review Audit will be completed weekly x 4 weeks by the ADON, reviewing all occurring Medication/Treatment Error Reports. This audit has been added to the nursing audit system for completion on all units quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up on all potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of Quality Assessment and Assurance Committee and QAPI. Date of correction: July 10, 2023 and on-going	
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 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.	F 755		7/10/23

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F 755	Continued From page 6 §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 observation, interview and document review, the facility failed to implement a system to ensure destruction of medications were promptly and properly witnessed to prevent potential loss or diversion for 1 of 2 residents (R5) reviewed for medication diversion. Findings include: R5's Order Summary report dated 6/13/23, identified Loratadine tablet 10 milligrams (mg) give 1 tablet by mouth one time a day for allergies.	F 755	F755 R5 remains in the facility. All staff responsible for medication destruction will be educated on correct process and procedure for medication destruction. All residents receiving medication in the facility have the potential for medications requiring destruction. The facility failed to implement a system to ensure destruction of medications were promptly and properly witnessed to prevent potential loss or diversion. System changes implemented include use of RxDestroyer on each medication cart for prompt disposal of dropped or refused	

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F 755	Continued From page 7 On 6/13/23 at 9:30 a.m. trained medication aide (TMA)-A administered 12 oral pill medications to R5 on the second floor south dining room. TMA-A placed a small medication cup on the table in front of R5. R5 picked one pill up at a time with her fingers, placed each pill into her mouth, and drank water. R5 attempted to place the last pill into her mouth, dropped the pill onto her chest, and then pill fell onto the floor. TMA-A picked up the pill off the floor with her hands and informed R5 she would get a new pill. TMA-A exited the dining room, walked to the medication cart, and placed the pill in a medication cup. TMA-A identified the white oblong pill as Loratadine tablet 10 mg for allergies, dispensed a new pill, and administered it to R5. TMA-A stated she would need to consult with staff nurse regarding the disposal of the medication, re-entered the dining room, and talked to licensed practical nurse (LPN)-A. TMA-A entered the locked medication room with the pill and completed the Medication Destruction Record (MDR): R5's MDR identified: Prescription number - 1498238 Drug name - Loratadine Strength - 10 mg Quantity - one Date - 6/13/23 Nurse: [Signed by TMA-A] RN (registered nurse) /Pharm (Pharmacy) witness: [signed by LPN-A] Method of Destruction: HWC TMA-A picked up pill cup with Loratadine pill in it and MDR, exited the medication room, locked the door, re-entered the dining room, and approached LPN-A. TMA-A requested LPN-A	F 755	medications, and development of a Medication Destruction Competency including both Rx Destroyer and MedSafe Use. The following documents were revised or measures implemented to reflect this system change: Medication Administration and Destruction policy and procedure has been revised to include 1) Disposal of Medications via Rx-Destroyer for prompt destruction of dropped or refused medications as soon as possible but not to exceed the end of the employee□s shift, and 2) the addition requiring two staff authorized to administer medications to be present when medications are placed in the MedSafe, or Rx Destroyer to prevent potential loss or diversion. Rx Destroyer has been added to each medication cart within the facility to provide prompt access to a means of destroying dropped or refused medications, and the ability for two staff authorized in medications administration to document the destruction on the Disposal of Dropped or Refused Medication Doses record. New form: BH # 845-23, Disposal of Dropped or Refused Medication Doses (dispose of single doses in Rx-Destroyer) will be kept in the medication cart allowing prompt access for two staff authorized to administer medications to record the destruction of dropped or refused medications. Both staff must observe the medication being placed in the RxDestroyer at the time of signature. New form: BH # 846-23, Checklist for Medication Destruction via RxDestroyer	

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	245453	A. BUILDING _____ B. WING _____	C 06/14/2023

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F 755	Continued From page 8 sign MDR document as a witness. LPN-A glanced into medication cup, in the column labeled RN/Parm Witness and signed document. TMA-A exited dining room re-entered the medication room and placed the Loratadine pill from the pill cup into the large zip lock bag located on the counter. The large zip lock bag already contained approximately over 30 unidentified lose pills, and five small bottles of eye drop medications. TMA-A stated the medications in the zip lock bag had been on the counter for "a while now" and would eventually be placed into the big destruction box for disposal. TMA-A also stated she was unaware of where the medication destruction box was located, used the zip lock bag because other staff were doing the same, and the medication room was always locked. During an interview on 6/13/23 at 1:35 p.m., LPN-B stated medications to be destroyed are entered onto the MDR for each resident in a logbook located in the medication room. LPN-B indicated a new system had been installed, a big blue disposal/destruction machine, where destroyed medications should be placed, located on two south in locked medication room. LPN-B also stated TMA- A dropped a pill this morning and she had co-signed the medication destruction record as a witness. LPN-B verified she did not visually witness TMA-A's disposal of the allergy medication pill and should have gone with her to see where she placed the pill but was too busy. During a follow up interview on 6/14/23 at 1:08 p.m., LPN-B stated a plastic bag of medication should not have been left in the medication room on the counter and those medications should have been destroyed right away. LPN-B verified the bag of lose medication pills to be destroyed	F 755	and MedSafe, has been assigned to all staff authorized to administration medications for completion. This checklist requires staff to demonstrate use of RxDestroyer for dropped and refused medication doses, and MedSafe for destruction of large quantities of discontinued or expired medications. This checklist has been added to the LB Broen Home Competency Training: TMA, LPN, RN summary. New form: BH # 847-23, Medication Destruction Audit, was created to require the facility to monitor its corrective actions to ensure the deficient practice is being corrected and does not recur. This audit was added to the quarterly nursing audit system within the facility. A staff meeting will be held 07/05/2023, for all staff authorized to administer medications. A review of all noted new and revised forms and policies and procedures will be completed by the DON and ADON. A demonstration of use of RxDestroyer will be presented. The importance of proper and prompt destruction of medications to prevent potential loss or diversion will be stressed. The Medication Destruction Audit will be completed weekly x4 on both units. This audit has been added to the nursing audit system for completion on all units quarterly ongoing. The DON will monitor audit findings and assure prompt follow-up on all potential concerns. Audit findings are an agenda item reported to the Resident Care and Customer Relations Committee, a sub-committee of Quality Assessment and Assurance and	

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F 755	Continued From page 9 had been on the counter in the medication room since last week or longer. LPN-B verified there were over 20 medication pills different sizes and numerous other pills the same color and size, along with bottles of eye drops, but unsure as to what they were. LPN-B indicated she had signed the MDR as a witness with other staff also and never went with them to visually witness the destruction of the medication. LPN-B indicated the importance to visually witness the destruction of each medication was to safe guard from drug diversion. LPN-B also stated staff were not clear on the disposal of medications process and need clarification. During an interview on 6/14/23 at 10:54 a.m., assistant director of nursing (ADON) stated staff are expected to fill out the MDR along with a witness. ADON also stated two staff are to witness the destruction of the medications and go together to the two south medication room and visually witness the medications being destroyed. ADON verified two witnessed was required to ensure there would be no drug diversion. ADON indicated staff should have not been allowed to have placed a plastic bag in the mediation room on the counter with lose mediation pills in it. ADON stated staff who signed off the destruction sheets should have destroyed the medications however they were not destroyed. ADON stated TMAs are allowed to co-sign to witness the destruction of medications but not allowed to have completed the disposal of medications, adding the licensed nursing staff have more authority and education as to what the medications are and should complete the destruction of the medications versus the TMA. During an interview on 6/14/23 at 12:04 p.m.,	F 755	QAPI. Date of correction: July 10, 2023 and ongoing.	

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F 755	Continued From page 10 TMA-B stated staff were expected to bring the medications to be destroyed down to two north medication room destruction bin rather than place them into a plastic bag. TMA-B indicated once staff had signed the MDR, placed medications in the plastic bag located on the counter in the two north medication room, they acknowledged they destroyed the medications and really had not. TMA-B stated once staff dump pills in the plastic bag without a bottle was unknown as to what there were. TMA-B verified an understanding a TMA had been able to destroy medications with a witness to help avoid removal of medications. TMA-B indicated she had entered the two north medication room, located on the counter was a large plastic bag with many pills, and unsure as to how many or what they were. TMA-B stated the plastic bag of pills had been there for more than two days. TMA-B carried the plastic bag with medications down to the two north medication room, disposed of the bag in the medication destruction bin without a witness and documentation. During an interview on 6/14/23 at 12:45 p.m., LPN-A verified she did not have another staff with her when she disposed of the medications in the medication safe located on two north. LPN-A stated another staff probably should have gone with to witness the destruction of the medications so that there is visual verification they were destroyed. LPN-A indicated she had placed 12 senokot (treats constipation) loose pills in a large zip lock bag in the past and left it on the counter in the medication room to add more pills to it to save on bags. LPN-A verified she had placed 42 lose multi vitamin pills in a large zip lock bag on 4/6/23 and was destroyed (7 days later) by TMA-B on 6/13/23.	F 755		

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F 755	Continued From page 11 During an interview on 6/14/23 at 3:30 p.m., director of nursing (DON) stated they expected staff to complete the MDR in the logbook located in the medication rooms prior to the destruction of medications. DON also stated two staff were required to physically be present to witness the destruction of the medications, to ensure it had been completed correctly, the proper medication had been destroyed, and help avoid diversion of medications. DON indicated witnesses could include TMA, LPN, RN, or pharmacy consultant, however a licensed staff was required to destroy the medications. During a telephone interview on 6/15/23 at 12:15 p.m., pharmacy consultant (PC) stated the facility had a Med Safe provided by the pharmacy located in locked room in a central area. PC also stated a nurse and a witness are required to fill out the destruction form. PC indicated it was not standard practice or appropriate for staff to place lose pills unidentified in a plastic zip lock bag and leave it on the counter to be destroyed later. PC stated any staff witness signed on the MDR record was expected to visualize the disposal of medications to verify the disposal of it and required two staff to be physically present. Review of facility policy titled Medication Administration and Disposal dated 1/2023, indicated medications will be disposed of according to regulations and will be placed in the MedSafe when applicable to ensure safe, accurate medication disposal.	F 755		

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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 6/13/23 and 6/14/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey. H54532695C (MN00094223) and H54531820C (MN00093004). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	2 000		