Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 16, 2024

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: July 18, 2024

Dear Administrator:

On August 14, 2024, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2024

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

RE: CCN: 245585
Cycle Start Date: July 18, 2024

Dear Administrator:

On July 18, 2024, 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
4140 Thielman Lane
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 October 18, 2024 (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 January 18, 2025 (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

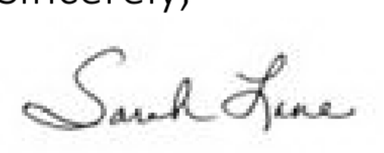
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 26, 2024

Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Re: Event ID: UXH811

Dear Administrator:

The above facility survey was completed on July 18, 2024 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
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00669	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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
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 7/17/24 through 7/18/24, 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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	00669	A. BUILDING: _____ B. WING _____	C 07/18/2024

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2 000	Continued From page 1 the survey: H55855860C (MN00104873); H55855947C (MN00101440); H55855948C (MN00101367). 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 07/18/2024

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F 000	INITIAL COMMENTS On 7/17/24 through 7/18/24, 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 during the survey: H55855947C (MN00101440); H55855948C (MN00101367); H55855860C (MN00104873),vwith a deficiency issued at F602. As a result of the investigation, additional deficiencies were cited at F609 and F610. 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		

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

Electronically Signed | 08/05/2024

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 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 observation, interview and document review, the facility failed to follow facility policy and procedure to prevent drug diversion for 1 of 3 residents (R3) reviewed. Findings include: R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis, Lyrica 100 mg three times daily for pain, and Zolpidem Tartrate 5 mg at bedtime for insomnia. R3's care plan as of 7/17/24, identified R3 had actual complications with pain related to current medical and physical status, pain in legs and all over at times. Further, R3's interventions for pain were medications as ordered, observe for effectiveness, non-pharmacological interventions which included snacks, remove stimuli, music, distraction, walk, 1-1 interactions, massage, art, aroma therapy, and deep breathing. R3's Pain Interview dated 6/24/24, R3 stated he had occasional pain in the last 5 days that had rarely or not at all effected sleep or day-to-day activities. R3 rated his pain a 3 out of 10 on the	F 602	F602 R3 received his Fentanyl Transdermal Patch as ordered by Physician. Documentation and application of narcotic transdermal patches were audited for residents. No other resident narcotic transdermal patch concerns were identified for alleged deficient practice. RN, LPN, TMA received inservice education on Controlled Substance Policy and Procedure, which includes narcotic transdermal patches. Administering Controlled Substances, Narcotic Medication & Fentanyl Audit forms were created and implemented to identify concerns with Controlled Substance Policy and Procedure. DON or Nursing Admin will complete daily audits RN or LPN or TMA utilizing the new Controlled Substance Audit Forms for 3 weeks. Audits will then be completed 3 times each week for 2weeks and then completed once per week for 2 weeks. Quarterly Audits to be completed after.	8/2/24

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F 602	Continued From page 2 numeric rating scale for pain intensity. On 7/17/24 at 2:19 p.m., licensed practical nurse (LPN)-A stated there were two locked medication carts and each cart contained its own locked controlled substance box. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new patch applied, and the old one destroyed, which both staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilized a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed and there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to. Also there were signatures of both LPN-A and LPN-B however LPN-A stated the signature was not in her writing. LPN-A stated TMA-A was suspected of "doing something" and was walked out of the facility and had not returned. On 7/17/24 at 3:07 p.m., during an observation, LPN-B opened narcotic book to page 68, both LPN-B and LPN-A verified the medication, number of tabs of medication that should be on the card and LPN-A punches out a pill into the medication cup. LPN-B and LPN-A again verify the remaining medications on the card, and both sign off in the narcotic book. LPN-A placed the medication card back into the lock box, in the	F 602	Controlled Substance Audit documentation will be forwarded to QA/QAPI Committee for review. Documented Controlled Substance audits will be reviewed by QA/QAPI Committee monthly or as needed. QA/QAPI Committee will modify plan and/or implement Inservice Education as identified from Controlled Substance Audit review to ensure system compliance and resolution. Compliance date: 08/02/2024	

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F 602	Continued From page 3 medication cart, and locked both the box and the cart, and LPN-A and LPN-B both walked to R3's room. R3 was utilizing the restroom, so LPN-A and LPN-B remained outside of R3's room until R3 was ready. LPN-A and LPN-B enter R3's room. R3 was sitting in his recliner and appeared comfortable. LPN-A administered the medication to R3, and LPN-B was present. Both LPN-A and LPN-B verify R3's Fentanyl patch was intact and did not appear to be tampered with. On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly seen two nurses signatures, and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log, and noticed a staff had forged LPN-B's signature, and that was when LPN-B knew it was TMA-A, and reported the suspected drug diversion immediately to the director of nursing (DON).	F 602		

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F 602	Continued From page 4 On 7/17/24 at 3:37 p.m., clinical services manager (CSM), from a contracted agency company, stated her team had received a phone call from administrator on approximately 6/25/24, reporting TMA-A was supposed to change a resident's Fentanyl patch however, TMA-A did not remove the old patch, took the new patch, and forged the initials of a nurse. CSM stated TMA-A's contract was terminated and the agency obtained a statement from TMA-A, where TMA-A admitted she re-applied the old Fentanyl patch on the resident, but did not mean to, and destroyed the new Fentanyl patch with a nurse. On 7/17/24 at 3:50 p.m., during a phone interview, TMA-A stated she was a contracted employee through a staffing agency and had worked at the facility since February of 2024. When asked if there were any incidents of drug diversion, TMA-A stated, "as far as I can tell there was an error, and I think everything was logged correctly", and then TMA-A hung up the phone and would not answer any further calls from the State Agency. Review of TMA-A's written statement dated 6/24/24, indicated TMA-A was working on R3's unit on 6/20/24, and was completing a normal medication pass at dinner time. TMA-A stated R3's order required his Fentanyl patch to be replaced and TMA-A had asked the nurse to verify the drug as it was a controlled narcotic. TMA-A stated immediately after, she took the patch along with R3's pills to R3 who was sitting at the dinner table. TMA-A handed R3 his oral medications and checked R3's shoulder for his old patch. TMA-A stated she removed the old patch, had the old patch in one hand and the new in the other hand, and applied the patch to the	F 602		

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F 602	Continued From page 5 shoulder area and went back to the medication cart with a patch and placed it into the medication cup to be destroyed after dinner time. TMA-A confirmed she was busy and distracted and did not destroy the patch immediately, and when noticed she still had the patch, she asked the nurse for the keys to the medication room so we could destroy the patch. The destruction of the patch was witnessed by LPN-C, and they signed the medication destruction log. During interview on 7/18/24 at 9:47 a.m., administrator stated she was not aware of any recent drug diversion incidents or concerns. On 7/18/24 at 10:19 a.m., DON stated controlled substance procedure included verification from two nurses or a licensed nurse and a TMA, staff would obtain medication administration record for the resident, grab the narcotic book and both staff would need to verify the medication or patch was administered, as well as immediately destroying the old patch, and then both staff would sign off in the record. When asked if there had been any recent concerns regarding drug diversion, DON stated no. When asked about the incident related to R3's Fentanyl patch, DON stated she was out of office when the concern was brought up that TMA-A had replaced R3's Fentanyl patch "with something else", and DON was not part of the investigation and was unaware of any further details. DON stated upon returning to the facility, she did not do any additional investigating or implementing interventions to prevent reoccurrence. On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion because DON was out	F 602		

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F 602	Continued From page 6 ill from the facility. RN-A stated LPN-B had reported concerns related to TMA-A not changing R3's Fentanyl patch and forging LPN-B's signature. RN-A stated she emailed her investigation to DON, Admin-A, and Admin-B and RN-A's investigation which concluded the facility's-controlled substance policy was not followed, however could not prove TMA-A took the Fentanyl patch or forged the signature. On 7/18/24 at 11:18 a.m., LPN-B stated on the date the suspected drug diversion was discovered, she called DON and the DON came to the facility and LPN-B showed the DON the suspicious Fentanyl patch she placed in the locked medication cart. LPN-B stated DON did not stay at the facility long as she was ill, and DON stated she was going to contact RN-A. When asked about the day the Fentanyl patch was ordered to be changed by TMA-A, LPN-A stated she was "a little a way from her [TMA-A], and it looked like she put it [the Fentanyl patch] on, but I can't say for a fact she did". Further, LPN-B confirmed the facility-controlled substance policy and procedure was not followed because the second nurse (LPN-B) was supposed to be able to verify the controlled substance was administered, and immediately following the removal of the old Fentanyl patch, the patch was expected to be destroyed and verified by two nurses, which was not completed. On 7/18/24 at 11:53 a.m., LPN-C stated she recalls an incident about suspected drug diversion with TMA-A related to a Fentanyl patch. LPN-C stated she remembered the unit being "so busy" and TMA-A approached LPN-C and requested the medication room keys and TMA-A wanted to destroy a Fentanyl patch. LPN-C stated	F 602		

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	245585	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 602	Continued From page 7 she gave TMA-A the keys and noted TMA-A had a folded patch in her hand, but could not confirm it was Fentanyl, a date or whose patch it was. LPN-C stated she watched TMA-A through the small window of the medication room door and observed TMA-A drop "something" into the destroyer. LPN-C confirmed she was unable to verify a Fentanyl patch was destroyed, as she did not go into the medication room with TMA-A, and LPN-C confirmed she did not sign the narcotic book or the destruction of a medication book to verify she observed. Further, LPN-A stated she took the medication room keys back from TMA-A. On 7/18/24 at 12:32 p.m., Administrator-B stated he was new to the administrator role at the facility and Administrator-A had been the lead administrator. Further, Administrator-B stated RN-A had completed the investigation related to R3's Fentanyl patch and was getting guidance from Administrator-A. Administrator- B stated staff had reported suspected drug diversion regarding TMA-A and the discovery of the suspicious Fentanyl patch and LPN-B's signature did not match in the controlled substance books. On 7/18/24 at 12:47 p.m., Administrator-A stated she "honestly did not know" about the suspected drug diversion with R3's Fentanyl patch and stated she just became aware on 7/18/24. Administrator-A denied reporting TMA-A to the contacted staffing agency as well. On 7/18/24 at 12:58 p.m., RN-A stated she was notified on 6/24/24, by LPN-B. RN-A stated she observed the Fentanyl patch, and stated there was Tegaderm stuck to the patch. RN-A stated on the patch there was an impression in it that read 6/17/24, and then the Tegaderm that was over the	F 602		

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F 602	Continued From page 8 patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove drug diversion had occurred. Review of untitled document, a page from the Controlled Drug Record, dated 6/20/24, revealed destruction of Fentanyl patch for R3 occurred on 6/20/24, with TMA-A's initials in addition to another set of initials that are unidentifiable as either CD or DD, however LPN-B and LPN-C denied signing the page for the Fentanyl Patch destruction. Review of Controlled Substance Administration and Accountability policy dated 3/11/24, indicated the facility would have safeguards in place to prevent loss, diversion, or accidental exposure. Further, policy indicated two licensed staff must witness any disposal or destruction of a controlled substance and document on the drug disposition record. Policy direct staff all controlled drug patches removed from patients are disposed of in such a manner as to prevent diversion, after removing the patch, the used patch was folded in half so that the sticky side sticks to itself and placed in the disposal system so that the controlled substance is non-retrievable, disposal of patches is witnessed and cosigned on the medication administration record in the blanks provided with each controlled drug patch order, and two signatures are required for documentation of controlled drug patch disposal.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		8/2/24

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F 609	Continued From page 9 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 to report suspected drug diversion to the State Agency (SA), as required, for 1 of 3 residents (R3) reviewed. Findings include: R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis. Review of the facility's internal investigation of	F 609	F609 Facility will report required allegations and investigate allegations of resident abuse, neglect, exploitation, or mistreatment. Resident allegations & concerns were reviewed and no further state reportables were identified for abuse, neglect, exploitation or mistreatment. Staff received inservice education on	

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F 609	Continued From page 10 suspected drug diversion: - Licensed practical nurse (LPN)-B notified DON on 6/23/24, R3's Fentanyl patch "did not look right" when removed. Fentanyl patch under the Tegaderm had 6/17/24 date in black pen and Tegaderm had the date of 6/20/24 in Sharpie marker. - Registered Nurse (RN)-A sent email to director of nursing (DON), administrator-A, and administrator-B on 6/24/24, which included R3's Fentanyl Investigation On 7/17/24 at 2:19 p.m., LPN-A stated there were two medication carts and each cart contained its own controlled substance box which required a key to unlock. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new applied, and the old one destroyed, which the staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilizes a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to, there were signatures of both LPN-A and LPN-B however LPN-A stated the signature was not in her writing. LPN-A stated TMA-A was suspected of "doing something" and was walked out of the facility and had not returned.	F 609	Abuse & Neglect Policy and Procedure which included required reporting of resident abuse, neglect, exploitation, or mistreatment. The DON is the Abuse Coordinator and will ensure communication to the Administrator. The Morning IDT meeting will review resident concerns. Allegations of resident abuse, neglect, exploitation or mistreatment that are required, will be reported to MN Department of Health and investigated. Allegations of resident abuse, neglect, exploitation or mistreatment will be reported to the QA/QAPI Committee with investigation. Documented allegations of resident abuse, neglect, exploitation, or mistreatment and investigations will be reviewed by QA/QAPI Committee monthly or as needed. QA/QAPI Committee will modify plan and/or implement further inservice education as identified from review of allegations of abuse, neglect, exploitation or mistreatment to ensure system compliance and resolution. Date of Complaince: 08/02/2024	

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F 609	Continued From page 11 On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly see two nurses signatures and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log and noticed a staff had forged LPN-B's signature and that was when LPN-B knew it was TMA-A and reported the suspected drug diversion immediately to the director of nursing (DON). On 7/17/24 at 3:37 p.m., clinical services manager (CSM), from a contracted agency company, stated her team had received a phone call from administrator- A on approximately 6/25/24, reporting TMA-A was supposed to change a resident's Fentanyl patch however, TMA-A did not remove the old patch, took the new patch, and forged the initials of a nurse. CSM stated TMA-A's contract was terminated and the agency obtained a statement from	F 609		

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F 609	Continued From page 12	F 609		

TMA-A, where TMA-A admitted she re-applied the old Fentanyl patch on the resident, but did not mean to, and destroyed the new Fentanyl patch with a nurse.

On 7/18/24 at 9:47 a.m., administrator-A stated she was not aware of any recent drug diversion incidents or concerns.

On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion because DON was out ill from the facility. RN-A stated LPN-B had reported concerns related to TMA-A did not change R3's Fentanyl patch and forged LPN-B's signature. RN-A stated she emailed her investigation to DON, Admin-A, and Admin-B and RN-A's investigation concluded the facility's-controlled substance policy was not followed, however could not prove TMA-A took the Fentanyl patch or forged the signature.

On 7/18/24 at 12:32 p.m., Administrator-B stated he was new to the administrator role at the facility and administrator-A had been the lead administrator. Further, administrator-B stated RN-A had completed the investigation related to R3's Fentanyl patch and was working and getting guidance from administrator-A. Administrator-B stated staff had reported suspected drug diversion regarding TMA-A and the discovery of the suspicious Fentanyl patch and LPN-B's signature did not match in the controlled substance books.

On 7/18/24 at 12:47 p.m., administrator-A stated she was not aware of the suspected drug diversion until 7/18/24. Administrator-A stated she

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F 609	Continued From page 13 assumed the facility did not report to the SA because their investigation revealed there was not a diversion. Further, administrator-A stated staff were expected to report to the SA if the facility policy was not followed and there was harm that occurred, and specifically related to drug diversion staff were expected to report immediately once they discover there had been a diversion. Administrator-A stated the facility had a couple hours to investigate before "legally" having to report to the SA, so in this incident administrator-A would have investigated first. On 7/18/24 at 12:58 p.m., RN-A stated she was notified on 6/24/24, by LPN-B. RN-A stated she observed the Fentanyl patch, and stated there was Tegaderm stuck to the patch. RN-A stated on the patch there was an impression in it that read 6/17/24 and then the Tegaderm that was over the patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove drug diversion had occurred, and that was the reason for not reporting the suspected drug diversion to the SA. Review of Controlled Substance Administration and Accountability policy dated 3/11/24, indicated the facility would have safeguards in place to prevent loss, diversion, or accidental exposure. Further, policy directed staff any discrepancies which cannot be resolved must be reported immediately as follows: notify the DON, complete an incident report detailing the discrepancy, steps taken to resolve it, and all the names of all licenses staff working when the discrepancy was noted. Further, the DON must also report any loss of controlled substances where theft was suspected to the appropriate authorities such as local law enforcement, drug enforcement agency, state board of nursing, state board of pharmacy,	F 609		

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F 609	Continued From page 14 and possibly the state board for nursing home administrators. However, the policy lacked staff direction on when suspected drug diversion should be reported to the SA.	F 609		
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 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 to implement appropriate interventions to prevent additional diversion after an incident of suspected drug diversion occurred for 1 of 3 residents (R3) reviewed. Findings include: R3's Order Summary Report dated 7/17/24, indicated R3 received a Fentanyl Transdermal Patch every 72 hours for osteoarthritis, Lyrica 100	F 610	F610 - Corrected Facility will report required allegations and investigate allegations of resident abuse, neglect, exploitation, or mistreatment. Resident allegations & concerns were reviewed and no further state reportables were identified for abuse, neglect, exploitation or mistreatment.	8/2/24

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F 610	Continued From page 15 mg three times daily for pain, and Zolpidem Tartrate 5 mg at bedtime for insomnia. Review of the facility's internal investigation of suspected drug diversion: - Licensed practical nurse (LPN)-B notified DON on 6/23/24, R3's Fentanyl patch "did not look right" when removed. Fentanyl patch under the Tegaderm had 6/17/24 date in black pen and Tegaderm had the date of 6/20/24 in Sharpie marker. - Registered Nurse (RN)-A sent email to director of nursing (DON), administrator-A, and administrator-B on 6/24/24, which included R3's Fentanyl Investigation On 7/17/24 at 2:19 p.m., LPN-A stated there were two medication carts and each cart contained its own controlled substance box which required a key to unlock. LPN-A stated any time a controlled substance was going to be administered there needed to be two nurses or a licensed nurse and a trained medical assistant (TMA) present to verify and ensure no mistakes happen. LPN-A stated the process was the same for Fentanyl patches, verification by two nurses that the old patch was removed, new applied, and the old one destroyed, which the staff would sign the book acknowledging they were a witness. LPN-A stated R3 was the only resident currently residing in the building who utilizes a Fentanyl patch, and stated R3's pain had been managed and there had been no changes. Further, LPN-A stated there had been a recent incident with suspected drug diversion when R3's Fentanyl patch was being changed there was a patch on R3 that was clear and did not say Fentanyl in green like it was supposed to, there were signatures of both LPN-A and LPN-B however LPN-A stated the	F 610	Staff received inservice education on Abuse & Neglect Policy and Procedure which included required reporting of resident abuse, neglect, exploitation, or mistreatment. The DON is the Abuse Coordinator and will ensure communication to the Administrator. The Morning IDT meeting will review resident concerns. Allegations of resident abuse, neglect, exploitation or mistreatment that are required, will be reported to MN Department of Health and investigated. Allegations of resident abuse, neglect, exploitation or mistreatment will be reported to the QA/QAPI Committee with investigation. TMA-A was a contracted staff member. TMA-A contract was canceled and will no longer provide pass meds at the facility. RN, LPN, TMA received inservice education on Controlled Substance Policy and Procedure, which includes narcotic transdermal patches. Administering Controlled Substances, Narcotic Medication & Fentanyl Audit forms were created and implemented to identify concerns with Controlled Substance Policy and Procedure. DON or Nursing Admin will complete daily audits RN or LPN or TMA utilizing the new Controlled Substance Audit Forms for 3 weeks. Audits will then be completed 3 times each week for 2weeks and then completed once per week for 2 weeks. Quarterly Audits to be completed after. Controlled Substance Audit documentation will be forwarded to QA/QAPI Committee for review.	

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F 610	Continued From page 16 signature was not in her writing. LPN-A stated TMA-A was suspected of "doing something" and was walked out of the facility and had not returned. On 7/17/24 at 3:20 p.m., LPN-B stated staff were expected to verify, with two nurses, a Fentanyl patch was still intact and not tampered with once a shift. LPN-B also stated, staff were expected to place a Fentanyl patch on a resident, with two nurses, as well as removing an old patch and immediately destroying the old patch. Two nurses would have to witness both events and sign off to confirm. LPN-B stated recently there had been an incident of drug diversion with a suspected TMA. LPN-B stated she went to change R3's Fentanyl patch and had noticed the patch did not say Fentanyl in green writing, and faintly see two nurses signatures and the date of three days prior to when the patch should have been last changed, and there was a new Tegaderm strip placed on the old patch that had a new date written and TMA-A's initials in Sharpie marker over the old patch, even when the facility process required the initials of two nurses on the Tegaderm to confirm two staff had verified the patch administration. LPN-B stated she then went to look at the medication destruction log and noticed a staff had forged LPN-B's signature and that was when LPN-B knew it was TMA-A and reported the suspected drug diversion immediately to the director of nursing (DON). Review of Nurse Meeting minutes dated 7/8/24, lacked evidence of staff education or retraining related to the facility's controlled substance procedure. On 7/18/24 at 10:19 a.m., DON stated controlled	F 610	Documented allegations of resident abuse, neglect, exploitation, or mistreatment and investigations will be reviewed by QA/QAPI Committee monthly or as needed. QA/QAPI Committee will modify plan and/or implement further inservice education as identified from review of allegations of abuse, neglect, exploitation or mistreatment to ensure system compliance and resolution. Date of Complaince: 08/02/2024	

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F 610	Continued From page 17 substance procedure included verification from two nurses or a licensed nurse and a trained medication assistant (TMA), staff would obtain medication administration record for the resident, grab the narcotic book and both staff would need to verify the medication or patch was administered as well as immediately destroying the old patch and then both staff would sign off in the record. When asked if there had been any recent concerns regarding drug diversion, DON stated no. When asked about the incident related to R3's Fentanyl patch, DON stated she was out of office when the concern was brought up that TMA-A had replaced R3's Fentanyl patch "with something else" and DON was not part of the investigation and was unaware of any further details. DON stated upon returning to the facility, she did not do any additional investigating or implementing interventions to prevent reoccurrence. On 7/18/24 at 10:50 a.m., registered nurse (RN)-A stated she was made aware of the suspected drug diversion on 6/24/24, by licensed practical nurse (LPN)-B who reported TMA-A did not change R3's Fentanyl patch and forged the nurse's signature. RN-A stated she called the DON due to the DON being out of the facility ill. RN-A stated she completed the investigation for the suspected drug diversion and the investigation revealed the facility policy related to controlled substances was not followed, however there was no evidence the patch was tampered with. When asked if she saw the patch in question, RN-A confirmed she say the patch and stated on the patch there was an impression in it that read 6/17/24, and then the Tegaderm that was over the patch had a date of 6/20/24, in Sharpie marker. RN-A stated she could not prove	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 18 drug diversion had occurred. In addition, RN-A stated she was unaware if the facility completed staff education related to controlled substance procedure following the incident and could not provide evidence of this being discussed at the nursing meeting last week.	F 610		