Electronically delivered
July 27, 2020

Administrator
MN Veterans Home Silver Bay
56 Outer Drive
Silver Bay, MN 55614

Re: State Nursing Home Licensing Orders
Event ID: HQG611

Dear Administrator:

The above facility was surveyed on July 7, 2020 through July 9, 2020 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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
	245628	A. BUILDING _____ B. WING _____	C 07/09/2020

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F 000	INITIAL COMMENTS On 7/7/20, through 7/9/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5628015C H5628016C H5628017C H5628018C H5628019C H5628020C H5628021C H5628022C H5628023C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse,	F 602		8/6/20

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

Electronically Signed | 08/05/2020

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 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 interview and document review, the facility failed to ensure 12 of 18 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, and R13) reviewed for drug diversion were free from exploitation when a staff member took resident's narcotic pain medications for personal use. Findings include: R1's Admission Record printed on 7/9/20, indicated R1 had diagnoses which included Alzheimer's disease, chronic pain, pain in unspecified knee,and dementia. R1's Order Summary Report printed on 7/9/20, indicated an order for hydrocodone-acetaminophen tablet (narcotic pain medication) 5-325 milligram (mg), give one tablet by mouth every six hours as needed for chronic pain. Give one tablet by mouth in the evening related to other chronic pain. R2's Admission Record printed on 7/9/20, indicated R2 had diagnoses which included dementia, arthritis right wrist, primary osteoarthritis of right hip, osteoarthritis bilateral knee, and low back pain. R2's Orders Summary Report printed on 7/9/20, indicated an order to offer as needed (PRN) oxycodone (narcotic pain medication) during night	F 602	SILVER BAY VETERANS HOME POC response for F602 We currently have one monitoring camera in each of our medication rooms. We are exploring the benefit of adding a second camera in our medication rooms to enhance our ability to note abnormal standards of practice. Updates or concerns will be provided to our QAPI team as appropriate. This process is ongoing and is monitored in QI based on areas of concern. We have provided education and implemented change in the following areas: On 7/9 we sent out education on Diversion of Controlled Meds. This education included completion of a Controlled Medication Competency training. As well as Med Safe destruction process. All floor RN□s and LPN□s have completed this training on 7/30/2020. All future nurses will be required to complete this training during their initial orientation. Medication Administration training in Health Care Academy was assigned on 7/7/20. All floor RN□s and LPN□s have completed this training noted on 7/30/2020.	

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F 602	Continued From page 2 if resident is displaying pain. Oxycodone HCL tablet 5 mg give by mouth as needed for pain related to bilateral primary osteoarthritis of knee not to be used during the day. Oxycodone hydrochloride (HCL) tablet 5 mg give by mouth four times a day related to bilateral primary osteoarthritis of knee. R3's Admission Record printed on 7/9/20, indicated R3 had diagnoses which included Alzheimer's disease with late onset, and chronic pain. R3's Orders Summary Report printed on 7/9/20, indicated an order to give 8 mg of hydromorphone (narcotic pain medication) one half hour before scheduled and PRN dressing changes. Hydromorphone HCL tablet 8 mg, give 8 mg by mouth every four hours as needed for chronic pain. Lorazepam (antianxiety medication) 0.5 mg, give 0.25 mg by mouth every four hours as needed for anxiety by mouth oral or sublingual (under the tongue). Max one dose every four hours. R4's Admission Record printed on 7/9/20, indicated R4 had diagnoses which included Alzheimer's disease with late onset, bilateral primary osteoarthritis of knee, dorsalgia (pain in the upper back), and unspecified osteoarthritis. R4's Order Summary Report printed on 7/9/20, indicated an order for oxycodone HCL give 5 mg by mouth every four hours as needed for chronic low back pain and leg pain. Oxycodone HCL 5 mg by mouth four times a day for chronic low back pain and leg pain related to unspecified osteoarthritis.	F 602	The following training is in process for all floor RN□s and LPN□s: A) Medication Administration Review that includes explanation of new audits for: " Controlled Medication Count and PRN Medication Administration use. " Atypical use, explanation of use and Performance correction plan if atypical use is noted as a concern. " This plan will use the following progressive process as appropriate: 1. Provide employee with just in time training and EAP reminder. 2. Provide a letter of expectation. 3. Follow the disciplinary process. " The following policies have also been assigned to be reviewed by licensed floor RN□s and LPN□s: Drug Disposition, Medication Storage and Security as noted previously. The processes noted above will be completed by, 8/31/2020. Employees are provided the previously mentioned training on their next scheduled day to work. The education/Training process will be followed by our QAPI team. A PRN Medication audit Report is being run to review for frequency of controlled prn use, who administered, non-pharmacological use to monitor for any atypical patterns. The PRN Medication Audit Report information will be reported and followed by our QAPI team. This process will be followed monthly x3 if no concerns are noted they will be followed quarterly x 3 if	

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F 602	Continued From page 3 R5's Admission Record printed on 7/9/20, indicated R5 had diagnoses which included sacrococcygeal disorders (tailbone disorders include tailbone injuries, pain), chronic pain, vascular dementia with behavioral disturbance, and dorsalgia. R5's Order Summary Report printed on 7/9/20, indicated an order for Methadone HCL (narcotic pain medication) 5 mg, give 2.5 mg by mouth at bedtime related to other chronic pain. R6's Admission Record printed on 7/9/20, indicated R6 had diagnoses which included Alzheimer's disease with early onset, dementia, chronic pain, gout, and primary osteoarthritis unspecified shoulder. R6's Order Summary Report printed on 7/9/20, indicated an order for fentanyl patch (long acting narcotic pain patch) 72 hour 25 micrograms (mcg), apply one patch transdermally in the afternoon every three days related to other chronic pain. R7's Admission Record printed on 7/9/20, indicated R7 had diagnoses which included dementia with behavioral disturbance, and spinal stenosis cervical region (a narrowing of the spaces within the spine which can put pressure on the nerves that travel through the spine). R7's Order Summary Report printed on 7/9/20, indicated R7 had orders for hydromorphone HCL 4 mg, give by mouth every one hours as needed for pain/shortness of breath, max one dose hourly. Methadone 5 mg, give 2.5 mg by mouth every 12 hours for control of pain. Lorazepam 0.5 mg, give by mouth every four hours as needed for	F 602	no concerns, we will use a spot audit approach.	

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anxiety or nausea, restlessness, related to unspecified dementia with behavioral disturbance.

R8's Admission Record printed on 7/9/20, indicated R8 had diagnoses which included unspecified abdominal pain, fracture of right femur, fracture of second and third lumbar vertebra, dementia, anxiety, chronic pain, osteoarthritis, intervertebral disc degeneration, and radiculopathy lumbar region (disease involving the lumbar spinal nerve root, can manifest as pain, numbness, or weakness of the buttock and leg).

R8's Order Summary Report printed on 7/9/20, indicated R8 had orders for methadone HCL 10 mg, give by mouth three times a day related to other chronic pain. Morphine Sulfate tablet (narcotic pain medication) give 30 mg by mouth every one hours as needed for pain or shortness of breath. Lorazepam tablet 1 mg, give by mouth every day and evening shift related to generalized anxiety disorder. Lorazepam 1 mg, give one tablet by mouth every four hours as needed for anxiety.

R9's Admission Record printed on 7/9/20, indicated R9 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, and unspecified osteoarthritis.

R9's Order Summary Report printed on 7/9/20, indicated R9 had orders for hydromorphone HCL 2 mg by mouth every one hours as needed for pain or shortness of breath, max one dose per hour. Methadone HCL tablet 5 mg, give 2.5 mg by mouth at bedtime for pain. Lorazepam tablet 0.5 mg, give 0.25 mg by mouth every four hours as

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needed for anxiety or restlessness.

R10's Admission Record printed on 7/9/20 indicated R10 had diagnoses which included dementia, cellulitis of right toe, and anxiety disorder.

R10's Order Summary Report printed on 7/9/20, indicated R10 had orders for morphine sulfate solution 20 milligram per milliliter (mg/ml), give 5 mg by mouth every two hours as needed for pain or respiratory distress. Lorazepam tablet 0.5 mg, give 0.25 mg by mouth every four hours as needed for anxiety.

R12's Admission Record printed on 7/9/20, indicated R12 had diagnoses which included Alzheimer's disease, dementia, unspecified osteoarthritis, and low back pain.

R12's Order Summary Report printed on 7/9/20, indicated R12 had an order for lorazepam 1 mg, give one tablet by mouth as needed for dementia with anxiety and restlessness, 30 minutes prior to dental visits.

R13's Admission Record printed on 7/9/20, indicated R13's diagnoses included pressure ulcer of left heel, vascular dementia, anxiety disorder, and chronic pain.

R13's Order Summary Report printed on 7/9/20, indicated R13 had an order for hydromorphone HCL 2 mg, give 1 mg by mouth every eight hours as needed for pain related to pressure ulcer of left heel. Okay to use before dressing change.

On 7/8/20, at 11:30 a.m. nurse practitioner (NP)-A was interviewed. NP-A stated several months ago

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she had concerns about the amount of narcotics LPN-A was giving to residents. NP-A stated she alerted the director of nursing (DON) that LPN-A was giving more PRN narcotic pain medication than any other nurse. NP-A stated she heard that LPN-A had spoken to R3's hospice nurse, and asked her to have R3's hydromorphone increased to double the amount of the pain medication, prior to dressing changes. The hospice nurse had the order increased to hydromorphone 8 mg on 5/26/20, at 5:01 p.m. NP-A stated she spoke to the wound care nurse about R3's dressing changes being more painful. The wound care nurse told NP-A she did not agree that R3 was having more pain with the dressing changes. NP-A stated she then changed R3's order back to hydromorphone 4 mg, 30 minutes prior to dressing changes on 5/26/20, at 5:26 p.m.

On 7/8/20, at 1:29 p.m. LPN-A was interviewed. LPN-A stated after she had dental work done in 12/19, it was painful, and she "kind of got addicted to pain medicine." LPN-A stated she started taking residents narcotic pain medications in May 2020, and she stated she only took their PRN narcotic medications. LPN-A stated if resident's needed something for pain, she made sure they got it. LPN-A stated, "It was just so easy."

On 7/9/20, at 11:32 a.m. the administrator, the DON, and the assistant director of nursing (ADON) were interviewed. The DON stated the concerns with LPN-A began in June 2020, after NP-A came to her with concerns about the amount of narcotics LPN-A was giving. The ADON recalled that she heard LPN-A had asked the hospice nurse to increase R3's pain

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medication prior to the dressing change, and the wound care nurse did not agree that the dressing changes had become more painful. Both the DON and the ADON stated they would expect the registered nurse (RN) to talk with the hospice nurse about the need to increase pain medications. The DON stated there were no progress notes to indicate R3 was having increased pain with dressing changes. The DON stated she suspected narcotic diversion after viewing video surveillance in June, following her conversation with NP-A. The DON stated they could not find any narcotic discrepancies to support their suspicion, however, they found LPN-A was giving narcotics without a pain assessment. On 3/5/20, the facility met with LPN-A, but their concern was about over-medicating residents, and not drug diversion. The administrator stated they were not concerned about narcotic diversion until after viewing surveillance video. The DON stated surveillance video indicated LPN-A was preparing narcotic pain medications for residents without first looking at the residents or looking at their medication records in the computer, and preparing narcotic pain medications immediately after completing the narcotic count.

LPN-A's employee file indicated the following:

On 7/22/19, LPN-A received counseling on 7/22/19, for destroying narcotics without a second nurse present.
On 2/5/20, LPN-A received a performance amendment/letter of expectation on 2/5/20, with expectations for immediate improvement. The letter indicated, "Medications will always be set up and administered following the 5 Rights of Administration. You will click on each medication

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after setting up and then approve after administration. PRN medication will be dispensed only after physical evaluation of the resident and after use/documentation on non-medication interventions. PRN's will be provided per the order medication indications in coordination with the resident's care plan. Multiple PRN medications will not be provided at one time. For 1-month PRN use must be assessed and approved by the RN prior to administration." LPN-A was encouraged to contact staff development if she needed additional training. On 4/15/20, LPN-A received training about charting non-medication pain relieving interventions before giving pain medications. On 6/3/20, LPN-A was called into the DON's office, and given a letter and explanation that she was being placed on an investigatory leave for failure to follow medication administration processes. On 6/4/20, LPN-A terminated her employment with the facility.

The facility reported nine complaints to the state agency (SA) for potential medication diversion. The initial report was filed by the facility on 6/4/20, for a potential medication diversion of controlled substances (narcotic pain medications) on 6/1/20. The eight other complaints were filed on 7/1/20, for a potential of medication diversion(s) of controlled substances (narcotic pain medications) on 6/4/20. All the involved residents resided on a secured dementia unit, and had narcotic pain medications both at scheduled times and PRN.

The facility policy Vulnerable Adult/Resident Protection Plan dated 11/19/19, defined abuse as also including the deprivation by an individual, including a caretaker, of goods. Misappropriation of resident property was also defined as

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F 602	Continued From page 9 permanent use of a resident's belongings or money without the resident's consent. The policy indicated they would train employees, through orientation and on-going sessions, on issues related to abuse and prohibition practices. They would monitor for staff burnout, which could lead to potential maltreatment of residents. The training included screening, training, prevention, identification, investigation, protection and reporting and response.	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 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	F 755		8/6/20

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F 755	Continued From page 10 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 ensure controlled medications were accurately reconciled for 1 of 1 residents (R7) while waiting for destruction to prevent the potential loss and/or diversion in 2 of 4 controlled medication counts. Findings include: R7's Face Sheet dated 7/9/20, indicated R7's diagnoses included spinal stenosis, cervical disc disorder with myelopathy, and spondylosis (spinal degeneration). R7's Physician Orders dated 7/9/20, included orders for methadone HCl (narcotic used to treat pain) 5 milligrams (mg) to give 2.5 mg by mouth (po) every 12 hours for pain control, and hydromorphone HCl (narcotic used to treat pain) 4 mg tabs to give 4 mg po every hour as needed for pain and/or shortness of breath (SOB) max one dose hourly. On 7/7/20, at 2:44 p.m. the Birch units narcotic count was observed with license practical nurse (LPN)-C and LPN-B. LPN-B began to reconcile (count) controlled medications that were being stored in a green bin waiting for destruction. The controlled medications that were in destruction bin were single pills stored in individual clear plastic baggies that were stapled shut. Each	F 755	Silver Bay□s POC response for F755: Education was sent out 7/9/20 on Diversion of Controlled Meds. This education included completion of a Controlled Medication Competency training. As well as Med Safe destruction process. All floor RN□s and LPN□s have completed this training on 7/30/2020. All future nurses will be required to complete this training during their initial orientation. The tracking of completion will be reported and followed in our QAPI team meetings. This process will be followed monthly x3 if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach The following training is in process for all floor RN□s and LPN□s: A) Medication Administration Review that includes explanation of new audits for: " Controlled Medication Count and PRN Medication Administration use. " Atypical use, explanation of use and Performance correction plan if atypical use is noted as a concern. " This plan will use the following progressive process as appropriate: 1. Provide employee with just in time	

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	245628	A. BUILDING _____ B. WING _____	C 07/09/2020

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F 755	Continued From page 11 clear plastic baggie was labeled with the resident's name, name and dosage of the medication, date the medication was placed in the baggie, reason medication was not given, and page number to locate the medication in the narcotic book. LPN-C was unable to find R7's methadone and hydromorphone in the narcotic book to ensure the number of medications were correct. LPN-C stated all the units received new narcotic books in June, 2020, and R7's hydromorphone and methadone were logged in the old narcotic book that were in the director of nurse's (DON) office. LPN-C verified R7's hydromorphone and methadone were not being reconciled since the units received new narcotic books in June. LPN-B placed R7's hydromorphone and methadone back into the green destruction bin in the locked medication cabinet. R7's hydromorphone and methadone were not reconciled. On 7/8/20, at 3:14 p.m. a second observation of Birch unit's narcotic count was completed with registered nurse (RN)-A and LPN-C at change of shift. LPN-C grabbed a green bin labeled destruction from the top shelf of the locked medication cabinet. The green bin contained small clear plastic baggies with individual controlled medications that were waiting to be destroyed. RN-A was unable to find R7's methadone and hydromorphone in the new narcotic book, and stated R7's methadone and hydromorphone must be logged in the old narcotic book that was in the DON's office. RN-A retrieved the old narcotic book from the DON's office, and LPN-C and RN-A reconciled R7's methadone and hydromorphone with the old narcotic book. RN-A stated the new narcotic book was put in place around 6/9/20, and further	F 755	training and EAP reminder. 2. Provide a letter of expectation. 3. Follow the disciplinary process. " The following policies have also been assigned to be reviewed by licensed floor RN□s and LPN□s: Drug Disposition, Medication Storage and Security as noted previously. The processes noted above will be completed by, 8/31/2020. Employees are provided the previously mentioned training on their next scheduled day to work. The education/Training process will be followed by our QAPI team. Audits of narcotic cabinets by Nursing Management started on 7/13/20. They are completed at least 3 times per week. Audit includes review of destruction log to assure all medications are noted and have been destroyed. Nursing Management will ensure destruction occurs and provide Just in Time Training as appropriate. The narcotic cabinet audits will be monitored monthly x 3 months then Quarterly. X 3 If no concerns, we will randomly spot audit to assure compliance. This process will be followed in QAPI meetings. Shift Count audits will be completed Bi-weekly x 3 months by Nursing Management or designee. The shift audits will be monitored monthly x 3 months then Quarterly. X 3 If no concerns, we will randomly spot audit to assure compliance. This process will be	

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F 755	Continued From page 12 stated she thought the narcotics in the green destruction bin were already destroyed so she had not been counting them at change of shift. On 7/8/20, at 3:28 p.m. RN-B stated Birch unit's old narcotic book was in the DON's office for an unknown length of time. RN-B stated R7's hydromorphone and methadone were not being reconciled at change of shift since the old narcotic book was in the DON's office. RN-B verified R7's hydromorphone and methadone were not transferred into the new narcotic book. RN-B further stated R7's hydromorphone and methadone should have been transferred into the new narcotic book and counted at each shift. On 7/9/20, at 10:20 a.m. the consultant pharmacist stated all controlled medications in the facility should be counted at every shift until they are disposed of to prevent opportunities for medication diversion. On 7/9/20, at 11:33 a.m. the DON stated R7's hydromorphone and methadone should have been transferred and logged into the new narcotic book. The DON stated all units received new narcotic books on 6/9/20, and the old books had been stored in her office since that date. The DON further stated nursing staff on Birch unit had not been requesting the old narcotic book to reconcile R7's methadone and hydromorphone. The DON stated the importance of tacking all narcotics would be to avoid drug diversion. The facility policy Drug Disposition revised date 12/17/20, directed Controlled Substance-Class II, III, IV, or V medications required nursing documentation for use, have system requirements for security, and required tracking	F 755	followed in QAPI meetings. Our pharmacy consultant has added medication destruction to the monthly review. Concerns will be reported in their report and included in the audits noted above. This change will be noted in their August 2020 review. The consultant audits will be monitored in our QAPI meetings as follows: monthly x 3 months then Quarterly. X 3, if no concerns, we will randomly spot audit to assure compliance.	

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F 755	Continued From page 13 for their disposition or destruction to prevent unwarranted use and provide for reconciliation.	F 755		

Electronically delivered

July 27, 2020

Administrator
MN Veterans Home Silver Bay
56 Outer Drive
Silver Bay, MN 55614

RE: CCN: 245628
Cycle Start Date: July 9, 2020

Dear Administrator:

On July 9, 2020, a survey was completed at your facility by the Minnesota Departments 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 9, 2020 (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 9, 2021 (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

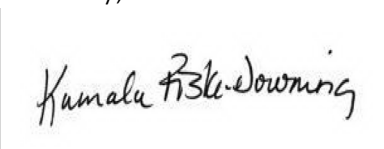
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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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: A complaint investigation was conducted on 7/7/20, through 7/9/20, to investigate the following complaints: H5628015C, H5628016C, H5628017C, H5628018C, H5628019C, H5628020C, H5628021C, H5628022C, and H5628023C.	2 000		

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2 000	Continued From page 1 As a result, all of the complaints were found to be substantiated with licensing orders issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	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 observation, interview, and document review, the facility failed to ensure controlled medications were accurately reconciled for 1 of 1 residents (R7) while waiting for destruction to prevent the potential loss and/or diversion in 2 of 4 controlled medication counts. Findings include: R7's Face Sheet dated 7/9/20, indicated R7's	21525	See SILVER BAY□S F755 correction plan noted above.	8/6/20

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21525	Continued From page 2	21525		

diagnoses included spinal stenosis, cervical disc disorder with myelopathy, and spondylosis (spinal degeneration).

R7's Physician Orders dated 7/9/20, included orders for methadone HCl (narcotic used to treat pain) 5 milligrams (mg) to give 2.5 mg by mouth (po) every 12 hours for pain control, and hydromorphone HCl (narcotic used to treat pain) 4 mg tabs to give 4 mg po every hour as needed for pain and/or shortness of breath (SOB) max one dose hourly.

On 7/7/20, at 2:44 p.m. the Birch units narcotic count was observed with license practical nurse (LPN)-C and LPN-B. LPN-B began to reconcile (count) controlled medications that were being stored in a green bin waiting for destruction. The controlled medications that were in destruction bin were single pills stored in individual clear plastic baggies that were stapled shut. Each clear plastic baggie was labeled with the resident's name, name and dosage of the medication, date the medication was placed in the baggie, reason medication was not given, and page number to locate the medication in the narcotic book. LPN-C was unable to find R7's methadone and hydromorphone in the narcotic book to ensure the number of medications were correct. LPN-C stated all the units received new narcotic books in June, 2020, and R7's hydromorphone and methadone were logged in the old narcotic book that were in the director of nurse's (DON) office. LPN-C verified R7's hydromorphone and methadone were not being reconciled since the units received new narcotic books in June. LPN-B placed R7's hydromorphone and methadone back into the green destruction bin in the locked medication cabinet. R7's hydromorphone and methadone

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21525	Continued From page 3 were not reconciled. On 7/8/20, at 3:14 p.m. a second observation of Birch unit's narcotic count was completed with registered nurse (RN)-A and LPN-C at change of shift. LPN-C grabbed a green bin labeled destruction from the top shelf of the locked medication cabinet. The green bin contained small clear plastic baggies with individual controlled medications that were waiting to be destroyed. RN-A was unable to find R7's methadone and hydromorphone in the new narcotic book, and stated R7's methadone and hydromorphone must be logged in the old narcotic book that was in the DON's office. RN-A retrieved the old narcotic book from the DON's office, and LPN-C and RN-A reconciled R7's methadone and hydromorphone with the old narcotic book. RN-A stated the new narcotic book was put in place around 6/9/20, and further stated she thought the narcotics in the green destruction bin were already destroyed so she had not been counting them at change of shift. On 7/8/20, at 3:28 p.m. RN-B stated Birch unit's old narcotic book was in the DON's office for an unknown length of time. RN-B stated R7's hydromorphone and methadone were not being reconciled at change of shift since the old narcotic book was in the DON's office. RN-B verified R7's hydromorphone and methadone were not transferred into the new narcotic book. RN-B further stated R7's hydromorphone and methadone should have been transferred into the new narcotic book and counted at each shift. On 7/9/20, at 10:20 a.m. the consultant pharmacist stated all controlled medications in the facility should be counted at every shift until they are disposed of to prevent opportunities for	21525		

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21525	Continued From page 4 medication diversion. On 7/9/20, at 11:33 a.m. the DON stated R7's hydromorphone and methadone should have been transferred and logged into the new narcotic book. The DON stated all units received new narcotic books on 6/9/20, and the old books had been stored in her office since that date. The DON further stated nursing staff on Birch unit had not been requesting the old narcotic book to reconcile R7's methadone and hydromorphone. The DON stated the importance of tacking all narcotics would be to avoid drug diversion. The facility policy Drug Disposition revised date 12/17/20, directed Controlled Substance-Class II, III, IV, or V medications required nursing documentation for use, have system requirements for security, and required tracking for their disposition or destruction to prevent unwarranted use and provide for reconciliation. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person could review medication policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21525		