DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 5, 2024

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: July 10, 2024

Dear Administrator:

On September 2, 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,

Kamala Fiske-Downing

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

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Electronically delivered

September 5, 2024

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

Re: Reinspection Results
Event ID: GGTX12

Dear Administrator:

On September 2, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2024

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 10, 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:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 10, 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 10, 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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2024

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders
Event ID: GGTX11

Dear Administrator:

The above facility was surveyed on July 9, 2024 through July 10, 2024 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:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 47497 On 7/9/2024 through 7/10/2024, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H56314802C (MN104184), with a deficiency cited at F602, F609, F610, and F761. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 602		8/31/24

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

Electronically Signed | 08/06/2024

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	Continued From page 1 Surveyor: 47497 Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1), was free from potential misappropriation of property and/or potential drug diversion of ordered narcotic pain medication. Findings include: Review of the 6/18/24 at 11:21 a.m., report to the State Agency (SA) identified on 6/15/24, the director of nursing (DON) received a call from the on-call registered nurse (RN)-A, notifying her that a hydrocodone (narcotic pain medication) was missing from the emergency narcotic medication kit (E-Kit). Licensed practical nurse (LPN)-B reported a new E-kit had been delivered earlier that day. After shift report, he had entered the medication room, unlocked the cabinet, and found the old E-kit and the new E-kit were stacked on top of one another. He reached up to remove the E-kits and the lock fell off the old E-kit. He identified that the red zip tie lock appeared to have been cut. He then realized the narcotic E-kit contents had not been verified. LPN-B then called the evening supervisor (RN-B) to report his findings. RN-B and RN-C reviewed the narcotic count books against the actual narcotic pill count for each medication. The narcotic book showed inconsistencies and had been signed out by LPN-A for the day shift of 6/15/24. The narcotic count was correct for 26 tablets, but the 26th dose foil seal was noted as broken and a tablet was taped back into the blister pack. RN-B and RN-C reported their findings to the DON. The DON interviewed LPN-B, RN-B, and RN-C then verified and added the counts from the narcotic E-kit to the narcotic	F 602	F602 Free from Misappropriation/Exploitation 1. Since 6/15/2024 Resident R1 has remained at baseline regarding signs of pain or discomfort. On 6/15/2024 a review of all residents for whom LPN-A administered narcotic medications was completed and no discrepancies were found within narcotic logs, medication cards, or elsewhere. By 8/16/2024 a review of all residents cared for by LPN-A with a narcotic order will be conducted to verify residents showed no increased signs of pain following narcotic administration and to verify no other instances of narcotic related concerns relating to LPN-A. On 6/17/2024 LPN-A was placed on investigatory leave and did not re-enter the facility after leaving her shift early on 6/16/2024. On 6/26/2024 LPN-A was terminated from employment at the MN Veterans Home Luverne. 2. All Residents have the potential to be affected. 3. On 8/2/2024 Administrator and DON reviewed policies titled Medication Disposition and Destruction and Controlled Medication Record. By 8/31/2024 Nurses will be educated by DON regarding the Medication Disposition Policy and the Controlled Medication Record Policy. 4. Audits will be conducted weekly for 4 weeks by the DON or designee for 5 randomly selected residents with an order for a narcotic medication to ensure that narcotic counts are accurate, that there are no signs of misappropriation/diversion, that pill cards	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

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F 602	Continued From page 2 count book. The old E-kit was short 1 hydrocodone tablet and contained 6 hydrocodone tablets but only contained 5. It was reported that earlier that day RN-C delivered the E-kit to the Green Wing (GW) to LPN-A. Several entries in the narcotic book for R1's hydrocodone had been written over by LPN-A. The page had a line through it and the count had been transferred to another new page by LPN-A. DON and LPN-B then examined the blister pack containing R1's hydrocodone tablets and identified the blister pack foil seal of the 26th dose had been broken and a tablet had been taped back in. The DON and LPN-B destroyed the 26th dose because the seal had been compromised. DON then called RN-C to review the findings. During that call, RN-C reported LPN-C had delivered the medications from the pharmacy delivery to the green wing, RN-C did not receive them from LPN-C but when she returned from a resident room at approximately 10:30 a.m., she found the medications were sitting on the back desk in the report room. She reported she saw that there was a narcotic e-kit there with an intact red lock tag on it. She placed the E-kit in the locked medication room. On 6/16/24, the DON returned to the facility to investigate further. RN-C reported on 6/15/24 at approximately 9:15 a.m., she had been in the special care unit (SCU) and found a clear medication cup on a tray with an opened, single-pill blister pack of hydrocodone labeled "Found floor-MJ" with a pill inside. RN-C observed Page 29 of the green wing narcotic book (the log sheet containing R1's hydrocodone narcotic count) had been ripped out and then taped back in. Before LPN-A could be interviewed by facility management on 6/16/2, she left the facility that morning reporting a family emergency and did not return and could not be reached for	F 602	are intact, drug destruction completed by two nurses, and chart review completed for selected residents to ensure no signs of increased pain or discomfort. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 8/31/2024	

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F 602	Continued From page 3 interview. LPN-A was notified via phone that she would be placed on investigatory leave effective immediately and pending the outcome of the investigation. There was no mention that facility had notified law enforcement, or that they had verified the medication that had been found in the compromised packaging prior to destroying them. Review of the 6/21/24, 5 day investigation report to the SA identified on 6/20/24 at 9:00 a.m., LPN-A was contacted for interview. LPN-A reported she was "not certain" if she was present when the new narcotic medications had been delivered to the facility and had not accepted any medications to stock. LPN-A then noted she "may have" received the medication delivery. LPN-A admitted she had cut the lock on the old narcotic E-kit because when she had counted her medications in her cart, she found she was short 1 hydrocodone for R1. She reported she decided to "take 1" from the E-kit to replace it so her count would be correct. LPN-A then stated she went back to the cart with the hydrocodone medication from the E-kit. When she proceeded to do the count again, she stated R1's hydrocodone was partially punched out and hanging from the back of the their blister pack card. She reported she taped the back of the blister pack and placed the extra single dose from the E-kit in her pocket. She then reported later that morning she placed the "extra dose" in a med cup and wrote "Destroy" on the cup and left it in the med cart. She said she "forgot" to tell anyone about it. LPN-A never reported to any staff the count was allegedly "off" or that she had taken a single dose of hydrocodone from the E-Kit. She did admit to altering the narcotic logbook on page 29 of R1's hydrocodone medication, in an attempt to "make the count right" and had ripped page 29 out of the	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 602	Continued From page 4 log book but then taped it back into the book. She reported she "did not know" she could not change, alter, or write over entries in a narcotic count logbook or tear pages out. The DON noted she had reviewed R1's medical record and identified he had not shown any signs or symptoms of increased pain, or distress, she re-educated staff via email reminding them to not leave narcotic medication unattended and to always use two licensed nurses to count narcotics at the end of each shift. The investigation made no mention that they had notified their consulting pharmacist for guidance, that they notified law enforcement of the suspicion of a crime, or completed any audits or competencies to ensure deficient practice had been corrected. R1's 6/19/24, Minimum Data Set (MDS) assessment identified he had admitted to the facility in March of 2023. R1 was dependent on staff for all activities of daily living (ADL's) and had diagnosis of lower back pain and neuropathy. R1's June 2024 administration record identified he was administered one hydrocodone 5/325 milligrams (mg) three times daily. The administration record identified LPN-A had signed off in the electronic medical record that she had administered the medication on 6/15/24 at 8:00 a.m., and 12:00 p.m. Review of the narcotic book page 29 identified R1's hydrocodone medication, 1 tablet had been signed out as given by LPN-A on 6/15/24 at 8:56 a.m., and 1 tablet was signed out as given at 12:00 p.m. There were 4 entries on the page, under the column labeled "Amount Remaining" listed the number of tablets left after each	F 602		

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F 602	Continued From page 5 administration. The numbers were clearly hand-written over several times with black ink and barely legible. Each of the entries were signed in black ink by LPN-A The page had been torn out of the bound book, then taped back in. The page had a line through it with a note "transferred to page 31." Interview on 7/10/24 at 1:42 p.m., with LPN-C identified she realized that morning on 6/15/24,the medication had not been delivered so she went to check if they had been left at the door. She found the medication delivery containing the narcotic E-kit had been left at the door. The bin was secured with 2 zip ties. She delivered the medications to the appropriate wings. When she delivered medications and E-kit, the RN on that wing was not available so she told LPN-A she placed the medications on the table in the report room. LPN-A responded verbally she "would take care of it". LPN-C then left the area. Following the incident, she had received an email reminding staff to complete narcotic count at the end of each shift with 2 licensed staff and narcotics can never be left unattended prior to being double locked but did not recall seeing the DON complete any additional training, audits, or competencies. Interview on 7/10/24 at 3:15 p.m., with LPN-B agreed with the above findings and reported that he came in for his shift and when he went into the medication room and unlocked the cupboard there was the new kit and the old kit. He reached up to grab them out of the cupboard and the zip tie fell off the E-kit. The tail end of the zip tie was not long like it normally was, and it was "obvious" it had been cut. He reported it to the on-call RN. He and the DON completed the count of R1's	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	C 07/10/2024

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MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

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F 602	Continued From page 6 hydrocodone tablets and found the last dose had been opened. He and the DON had to destroy it because the package had been compromised. He recalled receiving training via email from the DON to complete counts with 2 licensed nurses at the end of each shift, but did not recall any additional training, audits, or competencies being completed with him following the incident. There was no indication the medication had been left for law enforcement as potential evidence of a crime, as the actual pill inside had not been verified to be hydrocodone. Interview on 7/10/24 at 11:31 a.m., with the DON identified she agreed with the above findings. She noted she audited all of the narcotic count logbooks in the facility. She ensured narcotic count was being completed by 2 licensed nurses at the end of each shift and she looked at the administration records of the other residents who used narcotic pain medication but did not document it anywhere. She agreed that she should have included that information in her final investigation summary. She identified R1's hydrocodone tablet and the tablet found on the counter in the report room both had to be destroyed because the integrity of the packaging had been broken. She did not report the findings to the police, the pharmacy consultant who provides oversite to the facility, or the board of nursing because she could not determine if LPN-A had taken the narcotic medication out of the facility, and she believed the two tablets that were found were likely the 2 tablets that were missing. LPN-A had been terminated as a result of the incident. The DON had only reviewed the current narcotic count and had not looked at past resident administrations LPN-A had administered to see if there was potential increase in pain over	F 602		

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	245631	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 602	Continued From page 7 shifts she had worked where medication was otherwise not normally given, or if there had been other instances of errors/documentation issues from LPN-A in the counting of narcotics. Review of the facilities 7/13/23, Drug Disposition policy identified diversion of medications is the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use. Medications will be disposed of if it was dispensed in error and the medication will be destroyed. Staff were to follow the facility policy for medication destruction and use 2 licensed nurses to destroy the medication and record it in the narcotic logbook. Review of the 8/2/19, Operating Procedure: L Controlled Medication Record policy identified staff were to properly record and reconcile controlled narcotic medication each shift with 2 nurses verifying each record. Discrepancies were to be reported. There was no mention of what staff should do if there was a suspicion of a crime, potential evidence gathering, notification of law enforcement etc.	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: §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	F 609		8/31/24

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F 609	Continued From page 8 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: Surveyor: 47497 Based on interview and record review, the facility failed to report to the law enforcement a suspicion of potential drug diversion and failed to notify the Board of Nursing for 1 of 1 nurse (licensed practical nurse (LPN)-A) whose employment was terminated. Findings include: Review of the 6/18/24 at 11:21 a.m., report to the State Agency (SA) identified on 6/15/24, the director of nursing (DON) received a call from the on-call registered nurse (RN)-A, notifying her that a hydrocodone (narcotic pain medication) was missing from the emergency narcotic medication kit (E-Kit). Licensed practical nurse (LPN)-B reported a new E-kit had been delivered earlier	F 609	F609 Reporting of Alleged Violations 1. On 6/15/2024 the medication found inside the card was verified to be hydrocodone by the DON prior to medication destruction. On 6/16/2024 the medication found in a resident room in a pill cup was verified to be hydrocodone by the DON prior to medication destruction. On 7/10/2024 our investigation regarding LPN-A was reported to the Rock County Sheriff s Office as well as the Minnesota Board of Nursing. On 6/17/2024 LPN-A was placed on investigatory leave and did not re-enter the facility after leaving her shift early on 6/16/2024. On 6/26/2024 LPN-A was terminated from employment at the MN Veterans Home Luverne. 2. All Residents have the potential to be affected.	

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F 609	Continued From page 9 that day. After shift report, he had entered the medication room, unlocked the cabinet, and found the old E-kit and the new E-kit were stacked on top of one another. He reached up to remove the E-kits and the lock fell off the old E-kit. He identified that the red zip tie lock appeared to have been cut. He then realized the narcotic E-kit contents had not been verified. LPN-B then called the evening supervisor (RN-B) to report his findings. RN-B and RN-C reviewed the narcotic count books against the actual narcotic pill count for each medication. The narcotic book showed inconsistencies and had been signed out by LPN-A for the day shift of 6/15/24. The narcotic count was correct for 26 tablets, but the 26th dose foil seal was noted as broken and a tablet was taped back into the blister pack. RN-B and RN-C reported their findings to the director of nursing (DON). The DON interviewed LPN-B, RN-B, and RN-C then verified and added the counts from the narcotic E-kit to the narcotic count book. The old E-kit was short 1 hydrocodone tablet and contained 6 hydrocodone tablets but only contained 5. It was reported that earlier that day RN-C delivered the E-kit to the Green Wing (GW) to LPN-A. Several entries in the narcotic book for R1's hydrocodone had been written over by LPN-A. The page had a line through it and the count had been transferred to another new page by LPN-A. DON and LPN-B then examined the blister pack containing R1's hydrocodone tablets and identified the blister pack foil seal of the 26th dose had been broken and a tablet had been taped back in. The DON and LPN-B destroyed the 26th dose because the seal had been compromised. DON then called RN-C to review the findings. During that call, RN-C reported LPN-C had delivered the medications from the pharmacy delivery to the	F 609	3. Administrator and DON reviewed the policy titled Vulnerable Adult-Resident Protection Plan on 8/2/2024. The policy states, If the suspected abuse is possibly a criminal offense, notify the police at the direction of the Administrator or designee. The designated staff will obtain a police file number and a copy of the police report, as applicable. The policy states, If an employee related abuse is substantiated, it will be reported to the appropriate registry or licensing board by designated staff at the MVH, as appropriate. Administrator is understanding of the policies, the need to report a possible criminal offense to the local authorities, and the need to report substantiated abuse to the appropriate registry or licensing board. Administrator will provide education to Social Worker and Nurse Supervisors regarding the Vulnerable Adult-Resident Protection Plan Policy by 8/31/2024. DON will provide education to nurses regarding the Vulnerable Adult-Resident Protection Plan Policy by 8/31/2024. 4. Audits will be conducted weekly for 4 weeks by the administrator or designee for all OHFC reportable events to ensure any possible criminal offense was reported to the appropriate authorities timely and any substantiated abuse was reported to the appropriate registry or licensing board timely. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 8/31/2024	

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F 609	Continued From page 10 green wing, RN-C did not receive them from LPN-C but when she returned from a resident room at approximately 10:30 a.m., she found the medications were sitting on the back desk in the report room. She reported she saw that there was a narcotic e-kit there with an intact red lock tag on it. She placed the E-kit in the locked medication room. On 6/16/24, the DON returned to the facility to investigate further. RN-C reported on 6/15/24 at approximately 9:15 a.m., she had been in the special care unit (SCU) and found a clear medication cup on a tray with an opened, single-pill blister pack of hydrocodone labeled "Found floor-MJ" with a pill inside. RN-C observed Page 29 of the green wing narcotic book (the log sheet containing R1's hydrocodone narcotic count) had been ripped out and then taped back in. Before LPN-A could be interviewed by facility management on 6/16/2, she left the facility that morning reporting a family emergency and did not return and could not be reached for interview. LPN-A was notified via phone that she would be placed on investigatory leave effective immediately and pending the outcome of the investigation. There was no mention that facility had notified law enforcement, or that they had verified the medication that had been found in the compromised packaging prior to destroying them. Review of the 6/21/24, 5-day investigation report to the SA identified on 6/20/24 at 9:00 a.m., LPN-A was contacted for interview. LPN-A reported she was "not certain" if she was present when the new narcotic medications had been delivered to the facility and had not accepted any medications to stock. LPN-A then noted she "may have" received the medication delivery. LPN-A admitted she had cut the lock on the old narcotic E-kit because when she had counted her	F 609		

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F 609	Continued From page 11 medications in her cart, she found she was short 1 hydrocodone for R1. She reported she decided to "take 1" from the E-kit to replace it so her count would be correct. LPN-A then stated she went back to the cart with the hydrocodone medication from the E-kit. When she proceeded to do the count again, she stated R1's hydrocodone was partially punched out and hanging from the back of their blister pack card. She reported she taped the back of the blister pack and placed the extra single dose from the E-kit in her pocket. She then reported later that morning she placed the "extra dose" in a med cup and wrote "Destroy" on the cup and left it in the med cart. She said she "forgot" to tell anyone about it. LPN-A never reported to any staff the count was allegedly "off" or that she had taken a single dose of hydrocodone from the E-Kit. She did admit to altering the narcotic logbook on page 29 of R1's hydrocodone medication, in an attempt to "make the count right" and had ripped page 29 out of the logbook but then taped it back into the book. She reported she "did not know" she could not change, alter, or write over entries in a narcotic count logbook or tear pages out. The DON had reviewed R1's medical record and identified he had not shown any signs or symptoms of increased pain, or distress, she re-educated staff via email reminding them to not leave narcotic medication unattended and to always use two licensed nurses to count narcotics at the end of each shift. The investigation made no mention the facility notified law enforcement. Interview on 7/10/24 at 1:42 p.m., with LPN-C identified she realized that morning on 6/15/24, the medication had not been delivered so she went to check if they had been left at the door. She found the medication delivery containing the	F 609		

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F 609	Continued From page 12 narcotic E-kit had been left at the door. The bin was secured with 2 zip ties. She delivered the medications to the appropriate wings. When she delivered medications and E-kit, the RN on that wing was not available so she told LPN-A she placed the medications on the table in the report room. LPN-A responded verbally she "would take care of it". LPN-C then left the area. Following the incident, she had received an email reminding staff to complete narcotic count at the end of each shift with 2 licensed staff and narcotics can never be left unattended prior to being double locked. Interview on 7/10/24 at 3:15 p.m., with LPN-B agreed with the above findings and reported that he came in for his shift and when he went into the medication room and unlocked the cupboard there was the new kit and the old kit. He reached up to grab them out of the cupboard and the zip tie fell off the E-kit. The tail end of the zip tie was not long like it normally was, and it was "obvious" it had been cut. He reported it to the on-call RN. He and the DON completed the count of R1's hydrocodone tablets and found the last dose had been opened. He and the DON had to destroy it because the package had been compromised. He recalled receiving training via email from the DON to complete counts with 2 licensed nurses at the end of each shift, but did not recall any additional training, audits, or competencies being completed with him following the incident. There was no indication the medication had been left for law enforcement as potential evidence of a crime, as the actual pill inside had not been verified to be hydrocodone. Interview on 7/10/24 at 11:31 a.m., with the DON identified she agreed with the above findings. She	F 609		

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F 609	Continued From page 13 noted she audited all of the narcotic count logbooks in the facility. She ensured narcotic count was being completed by 2 licensed nurses at the end of each shift and she looked at the administration records of the other residents who used narcotic pain medication but did not document it anywhere. She agreed that she should have included that information in her final investigation summary. She identified R1's hydrocodone tablet and the tablet found on the counter in the report room both had to be destroyed because the integrity of the packaging had been broken. She did not report the findings to the police, the pharmacy consultant who provides oversite to the facility, or the board of nursing because she could not determine if LPN-A had taken the narcotic medication out of the facility, and she believed the two tablets that were found were likely the 2 tablets that were missing. LPN-A had been terminated as a result of the incident. The DON had only reviewed the current narcotic count and had not looked at past resident administrations LPN-A had administered to see if there was potential increase in pain over shifts she had worked where medication was otherwise not normally given, or if there had been other instances of errors/documentation issues from LPN-A in the counting of narcotics. Interview on 7/10/24 at 4:09 p.m., with the consulting pharmacist identified she was not aware the facility had an incident of potential diversion. No one had called her to notify her or to request any guidance in this matter. If the facility had called her, she would have reviewed the investigation, the narcotic count, the facility policies, and offered guidance to the facility. Depending on her findings, she would have likely recommended re-training, and ongoing	F 609		

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F 609	Continued From page 14 documented audits for a period of time. She identified the facility does not typically notify her until the next QAPI meeting and that meeting had not taken place yet. Review of the 6/21/23 facility Vulnerable Adult-Resident Protection Plan Policy identified the facility will report to the state licensing authorities (board of nursing) and to law enforcement any knowledge it has of actions which may need to be reported to the licensing board which would indicate unfitness for services as a licensed professional.	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: Surveyor: 47497	F 610	F610 Investigate/Prevent/Correct Alleged Violation	8/31/24

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F 610	Continued From page 15 Based on interview and record review, the facility failed to compete a thorough investigation when it was reported a potential misappropriation of resident property/potential drug diversion had occurred. Findings include: Review of the 6/18/24 at 11:21 a.m., report to the State Agency (SA) and the 5-day investigation identified LPN-C had found a green tote containing medication including narcotics had been left by the delivery driver inside one of the doors at the facility unattended. LPN-C retrieved the bin and delivered the medication to each wing. When she delivered the medication from the bin to the Green Wing (GW), she was unable to locate the RN so she told LPN-A that she was placing the medication delivery on the table in the report room. LPN-A responded verbally that she would take care of it. The medication was left on the table for an unknown length of time, unattended and not locked. Later that day the after shift report LPN-B went into the medication room and opened the cupboard that holds the narcotic medication emergency kit (E-kit). There were 2 kits in the cupboard, the new one and the old one. He reached up to remove the two kits from the cupboard and the red zip tie lock fell of the new E-kit. The zip tie appeared to have been cut. He noted the E-kit had not been verified and he added it to the narcotic count book. He called the evening supervisor a RN-B and reported the incident. RN-B, RN-C, and LPN-B completed a count of the narcotic E-kit and found it to be short 1 hydrocodone (narcotic used for pain relief) tablet. The E-kit count was then counted again by LPN-B, and the director of nursing (DON) and it was confirmed that the e-kit was short one	F 610	1. Since 6/15/2024 Resident R1 has remained at baseline regarding signs of pain or discomfort. On 6/15/2024 a review of all residents for whom LPN-A administered narcotic medications was completed and no discrepancies were found within narcotic logs, medication cards, or elsewhere. By 8/16/2024 a review of all residents cared for by LPN-A with a narcotic order will be conducted to verify residents showed no increased signs of pain following narcotic administration and to verify no other instances of narcotic related concerns relating to LPN-A. On 6/17/2024 MN Veterans Homes Pharmacy Director was contacted regarding the potential drug diversion event. MN Veterans Homes Pharmacy Director is a licensed pharmacist in the State of Minnesota and provided guidance to our facility regarding the event. On 7/17/2024 our pharmacy consultant was notified of the potential drug diversion event. 2. All Residents have the potential to be affected. 3. On 8/2/2024 Administrator and Director of Nursing reviewed policy titled Vulnerable Adult-Resident Protection Plan. Administrator will provide education to Social Worker and Nurse Supervisors regarding the Vulnerable Adult-Resident Protection Plan Policy by 8/31/2024. DON will provide education to nurses regarding the Vulnerable Adult-Resident Protection Plan Policy by 8/31/2024. Administrator and DON met on 8/2/2024 and determined that any future events relating to missing medications should be reported	

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F 610	Continued From page 16 hydrocodone tablet. Review of the narcotic medication logbooks identified inconsistencies in R1's medication count page 29. The page had 4 entries all signed by LPN-A. The numbers in the column titled amount remaining had been written over with black ink several times and the numbers appeared to have been changed. The entries were no longer legible. The page had been torn out of the bound book and then taped back in and line was drawn through the page with a note "transferred to page 31" written at the bottom. The facility investigation identified in an interview with LPN-A that she was not aware that she could not alter the entries or tear a page out of the narcotic logbook. LPN-A identified that she realized during her shift that R1's hydrocodone medication was short 1 tablet, so she went into the med room and cut the zip tie lock off the E-kit and removed a hydrocodone tablet, she did not sign the narcotic medication out and did not notify anyone at the facility at that she had removed it. She later found the missing tablet partially punched out of R1's blister pack of hydrocodone and taped it back in. She left the other hydrocodone tablet that she had removed from the E-kit in the medication cart and planned to destroy it later that day but forgot. The next day 6/16/24, a clear medication cup was found in another wing on a medication tray. LPN-A said when she came in that morning, she found the cup in the med cart but did not know that was the hydrocodone tablet and she placed the tablet on the tray. LPN-A said she was not always completing her triple checks while administering medication. The investigation noted finding that staff had violated several facility medication policies. Interview on 7/10/24 at 1:42 p.m., with LPN-C	F 610	timely to both the MN Veterans Homes Pharmacy Director and the Consultant Pharmacist. By 8/31/2024 Nursing Supervisors will be educated by the DON on the need to report missing medications timely to both the MN Veterans Homes Pharmacy Director and the Consultant Pharmacist. 4. Audits will be conducted weekly for 4 weeks by the DON or designee for all medication errors to determine if the medication error involved a missing medication, and if so, that any medication errors that involved a missing medication have been reported to both the MN Veterans Homes Pharmacy Director and the Consultant Pharmacist timely. Audits will be conducted weekly for 4 weeks by the DON or designee for 5 randomly selected residents with an order for a narcotic medication to ensure that narcotic counts are accurate, that there are no signs of misappropriation/diversion, that pill cards are intact, drug destruction completed by two nurses, and chart review completed for selected residents to ensure no signs of increased pain or discomfort. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 8/31/2024	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 17 identified she realized that morning the medication had not been delivered so she went to check if they had been left at the door. She found the medication delivery containing the narcotic E-kit had been left at the door unattended, the bin was secured with 2 zip ties. She delivered the medications to the appropriate wings. When she delivered GW medications and E-kit the RN on that wing was not available so she told LPN-A that she placed the medications on the table in the report room, LPN-A responded verbally she would take care of it. She then left the area. She identified that following this incident she had received an email reminding staff to complete narcotic count at the end of each shift with 2 licensed staff and narcotics can never be left unattended prior to being double locked but did not recall seeing the DON complete any additional training, audits, or competencies. Interview on 7/10/24 at 3:15 p.m., with LPN-B agreed with the above findings and he recalled receiving training via email from the DON to complete counts with 2 licensed nurses at the end of each shift, but did not recall any additional training, audits, or competencies being completed with him following the incident. Interview on 7/10/24 at 11:31 a.m., with DON agreed with the above findings and identified she audited all of the narcotic count logbooks in the facility of the current medication counts, but made no documentation to show that had been completed. She ensured the narcotic count was being completed by 2 licensed nurses at the end of each shift and she looked at the administration records of the other residents who used narcotic pain medication but did not document her findings anywhere. She agreed that she should have	F 610		

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	245631	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 610	Continued From page 18 included that information in her final investigation summary. Interview on 7/10/24 at 4:09 p.m., with the consulting pharmacist identified she was not aware the facility had an incident of potential diversion. No one had called her to notify her or to request any guidance in this matter. If the facility had called her, she would have reviewed the investigation, the narcotic count, the facility policies, and offered guidance to the facility. Depending on her findings She would have likely recommended re-training, and ongoing documented audits for a period of time. She identified the facility does not typically notify her until the next QAPI meeting and that meeting had not taken place yet. Review of the 6/22/23. Vulnerable Adult-Resident Protection Plan policy identified misappropriation of resident property (aka their medication) was defined as a deliberate misplacement, exploitation, temporary, or permanent use of a resident's belonging or money without the resident's consent. Any staff who become aware of an allegation of misappropriation were to report the incident to their supervisor and facility leadership, and state agency and federally required entities. The investigation policy does note in the event of a suspicion of a crime, it is to be reported to law enforcement. It does not it state nurses involved who are terminated as a result of their practice or concerns over an investigation will be reported to their Board of Nursing.	F 610		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/31/24

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F 761	Continued From page 19 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on interview, and record review the facility failed to ensure 1 of 1 package of routine and controlled narcotic medication, delivered by a package delivery service, was immediately secured into staff custody upon arrival, and when transported by staff and delivered to another unit. Findings include: Interview on 7/10/24 at 1:42 p.m., with LPN-C	F 761	F761 Label/Store Drugs and Biologicals 1. On 8/5/2024 MN Veterans Homes Pharmacy Director contacted delivery company to reiterate the requirement to have deliveries brought to the main front entrance and that deliveries must be signed for. There have been no similar events since 6/15/2024 in which medications have been delivered and left unattended. 2. All Residents have the potential to be	

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F 761	Continued From page 20 identified on 6/15/24, she realized medication had not been delivered to the wing, so she went to check if they had been left at the door. She found the medication delivery containing the narcotic E-kit had been left at the door unattended. The bin was secured with 2 plastic zip ties. She delivered the medications to the appropriate wings. She told licensed practical nurse (LPN)-A that she placed the newly delivered medication on the table in the unlocked report room. LPN-A responded verbally she would take care of it. LPN-C. LPN-C failed to notify the DON or administrator of the lack of the delivery driver to drop off medication in a hand off and not leave the medication unattended where potential diversion could occur from passers-by. Interview on 7/10/24 at 11:31 a.m., with DON identified she had not been notified of the unsecured medication left by the delivery driver at the time LPN-C became aware. She also discovered during her investigation medications had been left unsecured in the break room by LPN-C and LPN-A and were not directly handed off to be secured immediately by staff. She agreed medications had the potential to be diverted if not secured appropriately upon arrival to the facility and once at the facility. She had not educated staff. She did however, notify the pharmacist of the medications being left unsecured at the door to the pharmacist. Interview on 7/10/24 at 2:46 p.m., with the pharmacist identified the facility notified him of the medications being delivered and left by the door unattended. He notified the package delivery company of the concerns and directed them to ensure medications delivered to the facility in the future must be handed off to a "person" and not	F 761	affected. 3. Administrator and DON reviewed policies titled Emergency Drug Kit and Controlled Medication Record on 8/2/2024. Nurses will be educated by the DON or designee regarding the Emergency Drug Kit Policy and the Controlled Medication Record Policy by 8/31/2024. Administrator and DON reviewed and revised the policy titled Pharmaceutical Procurement on 8/2/2024. Nurses will be educated by the DON or designee regarding the Pharmaceutical Procurement Policy by 8/31/2024. Nurse education will also include the need to inspect an unattended delivery for signs of tampering, followed by a count/verification of the correct number of medications inside the delivery. Education will include the need to notify a Nurse Supervisor immediately regarding any missing medications in a delivery or if a delivery shows signs of tampering. 4. Audits will be conducted daily for 4 weeks by the DON or designee to ensure that no deliveries have been left unattended and weekly for 4 weeks to ensure that emergency kit is stored properly and double locked in the medication room. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 8/31/2024	

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F 761	Continued From page 21 left unattended. . Review of the 3/30/23, Controlled Medication Policy identified that all new schedule II-IV medications (narcotic) orders will be entered into a bound narcotic book upon arrival and count will be verified. Licensed nurses will account for all narcotic medications and verify the count at the end of each shift. If any discrepancies are noted, the nurse manager was to be notified. There was no mention of ensuring immediate custody occurred as soon as medication was brought from the delivery driver, nor was there any indication for staff to report immediately to management if that occurred in the future so immediate action and education could be provided.	F 761		

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	00411	A. BUILDING: _____ B. WING _____	C 07/10/2024

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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: Surveyor: 47497 On 7/9/24 through 7/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders	2 000		

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

Electronically Signed | | 08/06/24

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2 000	Continued From page 1 were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H56314802C (MN104184), with a licensing order issued at Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Surveyor: 47497 Based on interview, and record review the facility failed to ensure controlled narcotic medication delivered by a package delivery service was immediately secured into staff custody upon arrival, and when transported by staff to another unit. Findings include: Interview on 7/10/24 at 1:42 p.m., with LPN-C identified on 6/15/24, she realized medication had not been delivered to the wing, so she went to check if they had been left at the door. She found the medication delivery containing the narcotic E-kit had been left at the door unattended. The bin was secured with 2 plastic	21610	CORRECTED	8/31/24

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21610	Continued From page 3 zip ties. She delivered the medications to the appropriate wings. She told licensed practical nurse (LPN)-A that she placed the newly delivered medication on the table in the unlocked report room. LPN-A responded verbally she would take care of it. LPN-C. LPN-C failed to notify the DON or administrator of the lack of the delivery driver to drop off medication in a hand off and not leave the medication unattended where potential diversion could occur from passers-by. Interview on 7/10/24 at 11:31 a.m., with DON identified she had not been notified of the unsecured medication left by the delivery driver at the time LPN-C became aware. She also discovered during her investigation medications had been left unsecured in the break room by LPN-C and LPN-A and were not directly handed off to be secured immediately by staff. She agreed medications had the potential to be diverted if not secured appropriately upon arrival to the facility and once at the facility. She had not educated staff. She did however, notify the pharmacist of the medications being left unsecured at the door to the pharmacist. Interview on 7/10/24 at 2:46 p.m., with the pharmacist identified the facility notified him of the medications being delivered and left by the door unattended. He notified the package delivery company of the concerns and directed them to ensure medications delivered to the facility in the future must be handed off to a "person" and not left unattended. . Review of the 3/30/23, Controlled Medication Policy identified that all new schedule II-IV medications (narcotic) orders will be entered into a bound narcotic book upon arrival and count will be verified. Licensed nurses will account for all	21610		

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21610	Continued From page 4 narcotic medications and verify the count at the end of each shift. If any discrepancies are noted, the nurse manager was to be notified. There was no mention of ensuring immediate custody occurred as soon as medication was brought from the delivery driver, nor was there any indication for staff to report immediately to management if that occurred in the future so immediate action and education could be provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review and revise policies and procedures for securing and storage of medication to prevent unauthorized access to those medications. Licensed nursing staff should be educated to the importance of properly securing medication from unauthorized access. The pharmacist and DON should perform measurable audits to ensure security is attained. The pharmacist and DON should conduct audits and report the results of those audits to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		