STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villas at New Brighton	825 First Avenue Northwest New Brighton, MN 55112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on interview and document review, the facility failed to implement policies and procedures for the use of methadone hydrochloride (HCl, a synthetic medication used to treat addiction) treatment for acquisition, administration, destruction, and an appropriate taper for 1 of 1 resident (R2) reviewed for medication administration. Additionally, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic diversion for 6 of 6 medication carts reviewed. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 was cognitively intact, and used opioids (medication used for pain relief). R2's care plan indicated a history of substance use with sobriety since 8/23, and R2 went to a methadone clinic for methadone treatment dated 11/6/23. R2's Medication Administration Record (MAR) dated May 2024, indicated R2 missed doses of methadone on 5/7/24, 5/22/24, 5/23/24, and 5/24/24. R2's progress note dated 5/7/24 at 12:43 p.m., indicated R2's methadone was on order. R2's provider orders dated 11/23/23 to 5/13/24, indicated methadone HCl methadone oral concentrate 10 milligrams (mg) /milliliter (ml) give 11.9 ml by mouth in the morning. R2's provider orders dated 5/13/24, indicated methadone HCl oral concentrate 10 milligrams (mg)/ milliliter (ml), give 10.7 ml by mouth in the morning for opioid dependence for 14 days, then give 9.6 ml by mouth for opioid dependence in the morning for 14 days. The order was discontinued on 5/31/24 by physician's assistant (PA)-A. (continued on next page)

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.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's provider progress notes dated 5/8/24 at 00:00, written by PA-A indicated R2 was prescribed methadone HCl oral concentrate 10 mg/ml, give 11.9 ml by mouth in the morning for opioid dependence. The provider indicated R2 was interested in discontinuing methadone, had received her last two weeks of doses available from the methadone clinic, and PA-A was going to consult the pain team for a plan moving forward. The progress notes further indicated R2 would not get into a wheelchair as it cut in to her sides. R2's progress note dated 5/8/24 at 2:38 p.m., indicated social worker (SW)-A picked up R2's methadone from the methadone clinic and was told R2 needed to be seen in the methadone clinic face-to-face, or be cut from the program. R2's progress note dated 5/20/24 at 00:00, by PA-A indicated R2 was prescribed methadone HCl 10 mg/ml, to administer 10.7 ml by mouth in the morning for 14 days, and then 9.6 ml by mouth in the morning related to opioid dependence. R2 reported general body achiness, muscular in nature. PA-A indicated the symptoms were due to a possible pneumonia or the decreased dose of methadone. PA-A further indicated she spoke to the facility pain management team on 5/20/24, and the pain management team agreed to take over the management of R2's methadone dosing. R2's progress note dated 5/23/24 at 4:00 p.m., indicated R2 was out of methadone, the provider was updated, R2 was experiencing pain and discomfort, and was expected to experience withdrawals. The progress note indicated the pharmacy refused to dispense it and medical doctor (MD)-A refused to prescribe it. R2's progress note dated 5/28/24 at 2:28 p.m., indicated SW-A brought R2 a wheelchair to go to an appointment at the methadone clinic, and R2 stated she could not sit in a wheelchair that long. The progress note indicated social worker (SW)-A asked R2 what her plan was when the methadone clinic discontinued her from the program and R2 responded she would have to just stop using it. R2's methadone order dated 6/7/24, written by PA-A, indicated R2's methadone was prescribed for chronic pain. On 6/25/24 at 12:25 p.m., medical doctor (MD)-B stated R2 was under the care of a methadone clinic for methadone dosing for opioid addiction. R2 was admitted to the facility in October of 2023, on what was supposed to be a short-term stay. There were rules about how many take-out methadone doses a resident could have, but it was working well between the facility and the methadone clinic with the facility social worker's help. R2 was in and out of the hospital due to infections, and the methadone clinic was informed by the hospital, not the facility, that R2's dose was tapered by the facility. It was a violation of regulations for the facility to adjust the doses. The methadone clinic consulted with R2's care team and determined the methadone clinic practitioners would see R2 in the hospital and at the facility, but R2 decided she didn't want to return to the methadone program. A PA at the methadone clinic spoke with MD-A and informed MD-A anyone else changing the dose was, Out of bounds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 12:49 p.m., licensed practical nurse (LPN)-A stated the methadone clinic dispensed 14 methadone doses for R2 on 5/24/24, SW-A picked them up and was informed they were R2 's last doses, and the doses would last through 6/5/24. The methadone clinic dispensed 14 methadone doses to SW-A on May 8th for use May 8th through May 21st, but the facility didn't pick up the doses until 5/24/24, and R2 missed doses on 5/22/24, 5/23/24, and 5/24/24. The facility started a methadone taper in May 2024, without consulting the methadone clinic, but there were rules that only the methadone clinic could perform the taper as the methadone prescriber. LPN-A further expressed concern about the facility's destruction of the remainder of each dose that was altered, if it was wasted appropriately, or if the methadone was dosed correctly. She explained the single-dose bottles were foil-sealed with the correct dose from which R2 was supposed to drink the full dose. The facility did not consult the methadone clinic for information about how to correctly administer the tapered dose from the single-dose bottle, acknowledged the facility could likely figure out how to administer the correct dose, but should have consulted the methadone clinic pharmacy or their own pharmacy first. MD-A called the methadone clinic on 6/14/24, to inquire about a dose taper but R2 was hospitalized on [DATE]. The methadone clinic learned from the hospital the facility already started the methadone taper, so the methadone clinic could no longer follow the patient and dispense doses after the facility provider improperly adjusted the doses. LPN-A stated, We didn't know what [the facility] was doing. The methadone clinic asked with each two-week dose pick-up, for a urine sample for urinalysis (UA) to test for R2's use of methadone, but only one was provided over the eight months. On 6/25/24 at 2:55 p.m., SW-A stated because R2 couldn't tolerate sitting in a wheelchair to transport to the methadone clinic, SW-A picked up methadone doses for R2 from the methadone clinic 14 doses at a time. The methadone program staff informed him in the early part of May [could not recall the date], R2 had to go to the methadone clinic for her doses, and R2 stated she was not going to go and was willing to just quit taking the methadone. He called the facility provider, physician's assistant (PA-A), to inform of this, and the provider stated they were unable to write the prescription for R2. He consulted with the facility pain management team who informed SW-A they could not write prescriptions for methadone for addiction, only pain management. He was unsure of the dates of any of the conversations with the providers. On 6/26/24 at 9:53 a.m., during a subsequent interview, SW-A acknowledged the nurses at the methadone clinic asked for UAs, and he told the facility nurses. He took two urine specimens to the methadone clinic during eight months he picked up methadone doses. The facility did not share with him why R2 was cut from their program, but was informed during the 5/24/24 pick-up, they were the last 14 doses the methadone clinic would provide. On 6/25/24 at 3:19 p.m., during an interview LPN-B stated on 6/13/24, when R2 went to the hospital for cellulitis, R2 was out of methadone, and the facility was unsure how to get more for the resident. R2 was required to get her methadone from a methadone clinic, and the facility providers could not prescribe it. After the taper from methadone 119 ml to 96 ml, some had to be wasted from the foil-sealed container. She put the wasted amount on a tissue in a paper cup and put it in the sharps container (needle disposal container). She looked online how to do the dose conversion but could not state how to perform the conversion. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 3:38 p.m., LPN-C stated the facility PA was performing the methadone taper. She had tried to order the PA-prescribed dose from the facility pharmacy, but was told the facility pharmacy could not fill it. She reviewed the narcotic book where R2's methadone was recorded, unit RCU2, pages 81 and 86, and acknowledged nurses did not co-sign wasting the unused portion of methadone, but stated it was the facility policy for two nurses to co-sign narcotic wasting. Further, she acknowledged the narcotic signature page headers were not completed with the medication prescription information, but the facility policy indicated it should have been. She stated the signature page header should include the narcotic name, the date it was prescribed, a dose, and the name of the provider who prescribed it. She further acknowledged nursing staff was expected to administer less than was prescribed, and two nurses should have wasted the excess together, In the chemical. Additionally, she acknowledged R2 did not receive methadone doses on 5/22/24, 5/23/24, and 5/24/24. On 6/25/24 at 4:56 p.m., pharmacist (P)-B stated the facility pharmacy was not able to prescribe methadone for anything other than pain. On 6/25/24 at 5:20 p.m., trained medication aide (TMA)-A stated when R2's methadone dose changed, she was required to waste some of the pre-filled bottle and wasted the excess by flushing it down the toilet. She acknowledged she did not always waste narcotics with a double signature, but acknowledged she did, as a TMA, perform narcotic wasting. On 6/26/24 at 10:23 a.m., MD-C stated the facility should not have changed R2's methadone dose, and the hospital learned of the change from R2, not the facility. When R2 ran out of methadone on 6/13/24, the facility had no plan on how to get more, so R2 was sent to the hospital coincidentally the same day for cellulitis. MD-C stated facility staff removed the methadone with a syringe from sealed containers and, Any pharmacist would have flagged this. MD-A planned to perform the methadone taper for R2, but then could not as it was prescribed for addiction and not pain. The taper occurred first, and then the methadone clinic discontinued R2's care due to the prescribing laws. On 6/26/24 at 10:59 a.m., R2 stated she wanted to taper off methadone, but thought the methadone clinic was going to taper it, not the facility. Her single-dose vials were brought to her open and she drank what they brought. She was concerned about what the facility was doing with her methadone dosing. On 6/26/24 at 11:06 a.m., PA-A stated she tapered R2's dose, Very slightly. She was alerted R2 used her last dose after R2 went to the hospital on 6/13/24 for cellulitis. She talked to MD-A's associate at the pain clinic who agreed to take over the dosing, but learned later the pain clinic could not dose the methadone. It was on [MD-A] to figure it out. There were too many cooks in the kitchen. If he was managing it, then he was managing it. On 6/26/24 at 12:02 p.m., the director of nursing (DON) stated she was not aware the methadone clinic required monthly urine testing, the nurses should not have punctured the seal on the foil-sealed doses from the methadone clinic, and should not have drawn the dose into a syringe. The facility providers did not know they could not adjust the methadone doses. The MAR was not correct to indicate methadone was used for pain. The DON acknowledged R2 missed doses of methadone when the facility ran out and didn't pick it up timely, and acknowledged the facility did not have a policy or procedures in place to manage methadone for addiction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 12:18 p.m., P-D stated methadone prescriptions from the facility contracted pharmacy could only be for pain, the dosing for pain was typically 5-30 mg, and for opioid dependence was between 60-120 mg. PH-D stated, The dose [R2] was prescribed told us it was not used for pain. If the facility providers wanted to decrease the dose, it was recommended the facility providers collaborated with the methadone clinic provides, and the medical record lacked indication that occurred. On 6/26/24 at 1:06 p.m., MD-A stated he was unsure why the methadone clinic quit following R2 as a patient but knew he could not write a prescription for R2's methadone for addiction. He learned after the patient went to the hospital the methadone clinic thought he was tapering the dose, but upon review of the order, PA-A from the facility tapered the dose. Only one provider could write a prescription for methadone addiction. He was not consulted when PA-A changed the dose. On 6/27/24 at 10:47 a.m., P-C stated if the methadone was dispensed from a methadone clinic, the facility contracted pharmacy could not also dispense it, and the methadone clinic would manage dose adjustments and tapers. She did not know the facility staff withdrew methadone from the doses provided by the methadone clinic to adjust the doses. After 6/13/24, the facility plan to ensure R2 received prescribed methadone was unknown and, That is part of the problem. I guess she would have had to quit cold turkey, because of the prescribing rules, and it appeared there was a lack of communication between the facility and the methadone clinic. The proper way to dispose of liquid methadone was in the medication safe. On 6/26/24 at 9:15 a.m., during document review of the narcotic books on each unit the following was identified: Unit RCU2's narcotic book lacked 19 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit RCU1's narcotic book lacked 20 of 152 narcotic count signatures from 6/1/24 a.m. shift to 6/26/24 a.m. shift. Unit LTC2's narcotic book lacked 22 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night. shift. Unit LTC1's narcotic book lacked 56 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU1a's narcotic book lacked 52 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Unit TCU2 a' s' narcotic book lacked 69 of 150 narcotic count signatures from 6/1/24 a.m. shift to 6/25/24 night shift. Additionally, R2's methadone records in the narcotic book, page 10, was not indexed in the narcotic book, and the information on the narcotic record / count sheet lacked information about the prescribing provider, the pharmacy, the directions, the dose, the prescription number, or prescription date. R2's methadone record in the narcotic book page 86 was not indexed in the narcotic book, and lacked information about prescribing provider, the pharmacy, the directions, the prescription number, and the prescription date. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 1:18 p.m., during a follow-up interview the DON stated the nursing staff and TMAs count narcotics together at the end of each shift, unless the nurse was working a double shift. The nurse who received a narcotic delivery would index the medication in the narcotic book, and complete a medication count sheet head fully with the name of the medication, prescribing provider, dosage, pharmacy name, prescription number, prescription date, and the transfer page number if the medication was transferred from another unit. The DON acknowledged medication indexed were not complete, shift count signatures were not completed at the end of each shift, and the medication information was not present on the signature pages. Medications should not run out, should be ordered ahead of time to ensure they did not. The facility did not have a policy about resident use of methadone clinics for addiction but should. Pre-filled doses should be dispensed as labeled or the medication administration staff should clarify the order and instructions with the pharmacy or provider. Additionally, she expected nurses to dispose of narcotics per recommended guidelines for the medication and the policy or ask for help. The Medication Storage in the Facility: Controlled Substance Storage policy dated August 2019, directed a controlled substance accountability record was prepared by the pharmacy/ facility and the following information was completed on the accountability form [narcotic book] upon dispensing or receipt of a controlled substance: Name of the resident, Prescription number, Name, strength, and dosage form of the medication, date received, quantity received, and the name of the person receiving the medication. The policy further indicated at each shift, or when keys were transferred, a physical inventory of all controlled substances was conducted by two licensed nurses and was documented. The Specific Medication Administration Procedures Policy dated April 2018, directed immediately after administration of a controlled substance the nurse would document administration immediately in the controlled substance sign out record [narcotic book]. Once removed from the package or container, unused or partial doses should be disposed of in accordance to the medication destruction policy.