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	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

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 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: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [NAME] 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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	245631	A. Building B. Wing	07/10/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 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 [NAME] 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 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. (continued on next page)

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	245631	A. Building B. Wing	07/10/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47497 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 [NAME] 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/10/24 at 1:42 p.m., with LPN-C 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 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.

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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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 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.