STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elim Wellspring	701 First Street Princeton, MN 55371

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** 47083 Based on interview and document review, the facility failed to properly account for 34 tablets of hydromorphone (a controlled narcotic pain medication) for 1 of 3 residents (R1) reviewed for controlled medications. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated diagnoses of infection of multiple sites of the spine, septicemia (infection in the blood) and low back pain. The MDS also indicated R 1 had recent spinal surgery and she had received scheduled and as needed pain medication. R1's care plan dated 9/17/24 indicated she had pain related to diagnosis of lumbar fusion (spinal surgical procedure) and complaints of back pain. R1's hospital discharge orders included an order for hydromorphone (a narcotic pain medication) 2 milligrams (mg) every 3 hours as needed for severe pain. R1 was discharged from the hospital on 9/17/24. R1's September 2024 medication administration record (MAR) indicated she received hydromorphone 2 mg on 9/17/24 and 9/19/24. On 10/15/24, nurse practitioner (NP)-A wrote an order to discontinue hydromorphone 2 mg. On 10/16/24 at 9:36 a.m. a progress note indicated R1 discharged to home at 9:00 a.m. On 11/5/24 at 9:45 a.m., the director of nursing (DON) stated R1 was discharged home from the facility on 10/16/24, and the hydromorphone was not sent home with R1. On 11/5/24 at 10:47 a.m., R1 stated she did not take the hydromorphone often while at the facility, as she did not have the need for it. She also stated she did not take the hydromorphone home with her when she discharged on [DATE]. (continued on next page)

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
	245494	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elim Wellspring	701 First Street Princeton, MN 55371

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	On 11/5/24 at 11:27 a.m., licensed practical nurse (LPN)-A stated she and LPN-B discovered R1's hydromorphone was missing on 10/21/24 around 7:00 p.m., when they conducted their narcotic count at the change of shift. When the medication was discovered to be missing, she sent an email to the DON to notify her of the discrepancy. On 11/5/24 at 1:19 p.m., LPN-B stated she remembered seeing R1's hydromorphone the morning of 10/18/24. She stated when she came to work on 10/21/24 at 7:00 p.m. she completed her narcotic count with LPN-A, and they discovered R1's hydromorphone was missing. LPN-A sent an email to the DON. On 11/5/24 at 2:34 p.m., the DON stated she would have expected the nurses to have called her immediately upon discovering any discrepancies with narcotic counts. She did receive an email regarding R1's missing hydromorphone. On 11/5/24 at 3:44 p.m., LPN-C stated he recalled seeing R1's hydromorphone on 10/18/24. He did not follow policy and did not verify the narcotics were physically present in the medication cart. It was, Kind of a trusting situation. He knew the process of viewing each actual medication and looking at the count sheet to verify the actual number of medications, and this was an essential step to the process of narcotic counting. On 11/5/24 at 4:31 p.m., the assistant director of nursing (ADON) stated narcotic counts should be completed anytime a new staff person worked on a medication cart. The oncoming nurse should be counting the bin/locked box of medication. The nurse who was leaving should be reviewing the book to verify the quantity. If there was any discrepancy, they were to notify the DON immediately. The ADON also stated discontinued medications should be destroyed timely with two nurses. On 11/6/24 at 9:22 a.m., the pharmacist stated all medications were destroyed on site. The pharmacy no longer accepted returned medications. Best practice was to destroy a medication as soon as it was discontinued. R1's Narcotic Record indicated 36 tablets were received on 9/17/24. 1 tablet was removed from the card on 9/17/24, and another tablet was removed on 9/19/24, leaving 34 tablets. The facility policy Narcotic Count dated 7/19 directed the count is done by having one nurse look at the index and corresponding sign out page. A second nurse confirms the quantity remaining in the medication card, box, or bottle. Both staff sign the count notebook to indicate the count was current. a) if the count is not correct, notify the nursing supervisor promptly and search for the missing medication(s). b) if missing medication(s) cannot be accounted for, notify DON (or designee) who will determine the appropriate course of action The facility policy Medication Disposition dated 2/23 directed controlled medications: 1. When a scheduled II-V medication is discontinued, upon resident death, or upon discharge of a resident when a schedule II-V medications are not sent with resident upon discharge these medication must be destroyed by DON (or designee) and a second nurse. 2. Medications are to remain locked in the locked narcotic box on the medication cart and will be counted per the narcotic count policy until they are removed for destruction. 3. As soon as practical after discontinuance, death or discharge the following should occur: Narcotic medications are destroyed via state and federally acceptable practices.