Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: November 4, 2022

Dear Administrator:

On December 2, 2022, we notified you a remedy was imposed. On December 22, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 12, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 4, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 29, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 4, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 12, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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January 18, 2023

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Reinspection Results
Event ID: USHZ12 and Y5G612

Dear Administrator:

On December 20, 2022 and December 22, 2022 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 surveys completed on November 4, 2022 and November 22, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered

November 29, 2022

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: November 4, 2022

Dear Administrator:

On November 4, 2022, 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, Unit 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 February 4, 2023 (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 May 4, 2023 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Electronically delivered
November 29, 2022

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: State Nursing Home Licensing Orders
Event ID: USHZ11

Dear Administrator:

The above facility was surveyed on November 4, 2022 through November 4, 2022 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, Unit 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245218	A. BUILDING _____ B. WING _____	C 11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

(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 On 11/3/22 through 11/4/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52185296C (MN87827), with a deficiency cited at F602 and F609. 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: Based on interview and document review the	F 602	Submission of this Allegation of	12/9/22

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

Electronically Signed | 12/05/2022

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 facility failed to ensure 2 of 3 residents (R1 and R2), were free from misappropriation of property via drug diversion of ordered narcotic pain medication when licensed practical nurse (LPN)-C was to have falsely noted giving the residents their pain medication. Findings include: Review of the 10/20/22 at 10:39 a.m., report to the State Agency (SA) identified the event had taken place on 10/15/22 at 5:30 a.m., when R2 reported she had not received oxycodone signed out in the narcotic book at 3:30 a.m. and 5:30 a.m. by LPN-C from the dates of 9/3/22 to 10/15/22. The report also identified R1 who was unable to verbalize pain and had symptoms of intractable pain when the LPN-C was on the schedule. Multiple staff had expressed concern regarding the LPN-C's behavior when working the night shift and would sign out narcotics and then go into the bathroom for an extended time. It was reported the LPN-C had a noticeable tremor at the beginning of his shift which disappeared by the end of his shift. R1's 8/10/22, Minimum Data Set (MDS) assessment identified R1 had severe cognitive impairment, total dependence for activities of daily living (ADLS), and no documented behavior. R1 received scheduled pain medication and demonstrated non-verbal indicators of pain. R1 had diagnoses which included anxiety disorder, contractures of upper and lower extremities, abnormal posture, anoxic brain damage, chronic pain syndrome, major depressive disorder, tracheostomy, dysphagia, muscle cramps and spasms, altered mental status, panic disorder, post-traumatic stress disorder (PTSD), and	F 602	Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. On 11/3/2022-11/4/2022, MDH completed a standard abbreviated survey and noted	

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F 602	Continued From page 2 traumatic brain injury (TBI). Review of her signed provider orders included a Fentanyl patch (a narcotic pain patch) 72 hour/25 micrograms (mcg) /hour (hr), Lorazepam 0.75 milligram (mg) via gastric tube (GT) four times daily (QID), oxycodone 5 mg GT-QID, citalopram 30 mg GT- every (Q) day (D), and ibuprofen 600 mg GT- QID. Review of medication administration record (MAR) for October and November identified documentation of pain medication administered as ordered with narcotic medication administered 7 out of 7 days. Review of the Narcotic log identified the Narcotic medications were accounted for and signed out as administered in both the handwritten Narcotic book and in the electronic record (PCC). Review of the 9/7/22 physician note identified R1 had chronic pain secondary to muscle contractures and was to have received scheduled pain medication in addition to as needed (PRN), orders for anxiety and discomfort. R1's current, undated care plan identified R1 had pain related to (r/t) spasticity, and contractures in multiple joints. R1 expressed pain non-verbally by grunting and facial grimacing along with crying and her face becoming red in appearance. Pain medications were to be administered as ordered and PRN when nonverbal signs/symptoms (s/s) of pain were observed. Staff were to monitor for side effects of pain medication and document nonverbal and behavioral signs of pain such as facial grimacing, withdrawal, or guarding, aggression, agitation, or crying.	F 602	the facility failed to ensure 2 of 3 residents were free from misappropriation of property via drug diversion. Director of Nursing will review Drug Diversion policy and procedures. Residents will be free from misappropriation of property. Facility will re-educate staff regarding the Drug Diversion policy and procedure. Facility will re-educate nursing staff regarding narcotic key process for shift-to-shift exchange. Facility staff will report suspicion of drug diversion directly to the Director of Nursing immediately. Facility will interview staff and residents on a weekly basis to ensure there are no suspicions of drug diversion. Pharmacy consultant will review narcotic discrepancy and report findings monthly. Pharmacy will conduct monthly audits of medication carts to ensure compliance. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Audits of the narcotic book and controlled drug count record will be conducted weekly for 2 months to ensure compliance. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ONGOING compliance and those solutions are sustained. Deficiency to be corrected 12/9/2022. Director of Nursing or designee will be responsible to ensure compliance.	

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F 602	Continued From page 3 R2's, 8/12/22 Quarterly, MDS identified her cognition was intact, she had mild depression and exhibited no behaviors. R2 was admitted with diagnoses which included heart failure, HTN, ESRD (renal insufficiency), diabetes, anxiety disorder, depression, morbid obesity, primary osteoarthritis left shoulder. R2 was to have scheduled and PRN pain medications including Tramadol 75 mg PO QID, and oxycodone 5 mg PO Q4H PRN. R2 received her scheduled medication PRN daily during the daytime hours when she was awake and active. R2's, Medication Administration Record (MAR), for October 2022 identified R2 received Oxycodone 26 of 31 days with pain rated at 9 or 10 of 10, during daytime hours, Tramadol 75mg PO was scheduled and administered QID. The only Oxycodone administered during the overnight hours was documented by the LPN-C. Review of the 10/20/22 at 8:20 a.m., physician progress noted identified evaluation and discussion of R2's level of pain since 9/2/22. R2 indicated she had not needed/requested PRN pain medications as the Narcotic Book had indicated. R2 stated her pain level was not intractable, it had not prevented sleep or prevented her from attending activities. Her pain was currently stable and manageable per resident verbalization. Interview on 11/3/22 at 12:47 p.m., with licensed practical nurse (LPN)-A reported she did not recall the exact date, but stated it was a couple of weeks ago, on a Friday night when the LPN-C came on duty at 6:30 p.m. and immediately went to his medication cart and started in the narcotic	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 drawer where he began preparing R3's medications, took them to R3, returned and began preparing R1's medications, by placing her narcotic medication in one cup and regular medication in a second. LPN-A stated R1 was not due for any scheduled narcotics at that time. She stated she had gone to R1's room and began cares and LPN-C entered the room, with one medication cup, crushed the medications, cocktailed them and administered via R1's G-tube. She reported the LPN-C competed the administration of R1's medications, walked out the door and immediately went into the bathroom. LPN-A stated while the LPN-C was in the bathroom, she had checked the narcotic book and R1's Ativan record had a dose signed out with a time of 9:05 p.m. and it was 7:00 p.m. When the LPN-C came out of the bathroom and joined her in a different resident room, she noted he had a bloody nose. When she commented on it, LPN-C became anxious and voiced excuses of dry air and allergies. LPN-A reported when the LPN-C went down the hall, she had rechecked the narcotic book to confirm what she had seen and stated she was going on break and telephoned the nurse manager (RN)-A to report what she had observed. RN-A instructed her to contact the DON to report her concerns, which she did. At about 8:05 p.m. LPN-A looked at the narcotic book and the time had been changed for R1's Ativan dose to 8:05 p.m. RN-A called back at about 9:00 p.m. to LPN-A to request an update and directed her to wait about 20-30 minutes and check R1 for any S/S that had not received her Ativan. LPN-A stated R1 was non-verbal and when she became upset, she would make a squealing noise, become red and start crying. When LPN-A went into R1's room, she reported she had been displaying those S/S of agitation.	F 602		

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F 602	Continued From page 5 LPN-A reported she had emailed the DON with a summary of what she had observed. LPN-A reported the following day she had observed the LPN-C repeat the same actions with medications. LPN-A stated when she had received shift report it was reported R1 had been upset and agitated most of the day following the 10/15/22 shift. LPN- A reported on 10/15/22, when LPN-B had come on duty for the afternoon shift he had come to her to ask how to handle a concern with the Narcotic book. LPN-B stated he had gone to talk with R2 prior to his shift and she had reported not receiving a dose of oxycodone that the LPN-C had supposedly administered to her that morning, and review of the Narcotic log for R2's oxycodone identified the LPN-C was the nurse that had signed out oxycodone for R2 on the morning of 10/15/22. LPN-A instructed LPN-B to notify the DON to report his concerns. Interview on 11/3/22 at 1:35 p.m., with LPN-B reported he had been the charge nurse on the weekend of 10/15/22 and 10/16/22 and had stopped to speak with R2 who told him about supposedly receiving an oxycodone at 5:30 a.m. the morning of 10/15/22, and it bothered her, but she had not received any medication at 5:30 a.m. on that morning. LPN-B reported he had retrieved the Narcotic log and the LPN-C was the only nurse that had made changes to times on 3 narcotic cards and the only nurse that administered R2's PRN oxycodone on the night shift. LPN-B repotted the logged times were exactly 4 hours LPN-Cart and he was the only nurse that had signed R2's oxycodone between the times of 2:30 a.m.- 5-6:00 a.m., which LPN-B identified as unusual because R2 was usually sleeping during that time and did not complain of	F 602		

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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 602	Continued From page 6 pain or request medication. LPN-B reported he was concerns and had made copies of the log and reviewed the administration of narcotics by LPN-C and it was noted to be taking place more frequently. LPN-B reported he was aware the LPN-C worked the 12-hour night shift and there was a rumor he had been suspected of similar conduct previously. Following the report by R2, LPN-B had looked at the assignment sheets and noted the LPN-C had supposedly administered the oxycodone to R2 at 2:30 a.m. and 5:30 a.m. on 10/15/22 and that was not the wing he had been assigned to work on. LPN-B had also questioned why the LPN-C had supposedly given her medication when he was not the nurse assigned to her wing on 10/15/22. Interview on 11/4/22 at 9:44 a.m., with the director of nursing (DON) reported R1 was in a semi-vegetative state and not able to verbalize her needs, so staff must anticipate and provide her needs. R1 can smile at times, and grunts with increased vocalization due to having a tracheostomy, but the level of sound she makes with facial expression is how staff determine pain. R1 was also observed to cry and became flushed when she had discomfort. The day after the reported incident, the DON reported she had assessed R1 and observed grunting, redness, and tears running down her face. The DON stated she had questioned staff and they reported that was how they were aware R1 was having pain. Interviewed staff reported they had observed indicators of pain, following a shift worked by the LPN-C and since he is no longer in facility the S/S had decreased. It was reported when R1 received her scheduled medications for pain and anxiety her S/S were minimal, and she would relax and sleep. The DON stated she had	F 602		

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	245218	A. BUILDING _____ B. WING _____	C 11/04/2022

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F 602	Continued From page 7 received a call on the evening of 10/15/22 but was not concerned there was an issued until she returned to work on the morning of 10/17/22 and received the emails summarizing the concerns. At that time, she had begun her investigation and the LPN-C had been suspended pending the investigation and was removed from the schedule following the end of his shift on 10/16/22. During that interview with LPN-B, she reported she had left her medication keys on the desk when she had gone on break, and LPN-C had covered that unit when she was gone. Following the incident, education had been provided to nursing staff about leaving keys unattended, and if a nurse was working as an NA, they were not to have access to a medication cart, unless the nurse assigned to that unit asked for assistance. If the assigned nurse was going out of building the medication keys were to be given to the charge nurse or nurse manager for security. If a nurse was covering for a nurse leaving on break, and there was a need to administer a narcotic or PRN med they were required to update the assigned nurse, they were covering for and make a progress note. Review of the September 2022, Narcotic Management policy identified drug diversion was to be handled by the local police, the Office of Health Facility Complaints, and the Board of Nursing. The policy did not contain any actions to be completed by the facility if there was a suspicion of a drug diversion. Review of the July 2021, Ebenezer policy/procedure Vulnerable Adult-Abuse Prevention Plan identified all violations involving abuse and/or misappropriation of resident property, are reported to the SA not later than 2	F 602		

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F 602	Continued From page 8 hours after the allegation is made. The policy identified Abuse as including not providing a resident goods or services that are necessary to avoid pain or mental anguish. An alleged violation was defined as a situation or occurrence that was observed and/or reported by staff, or other person and had not yet been investigated, but could result in abuse or misappropriation of resident property.	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 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	F 609		12/9/22

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F 609	Continued From page 9 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely report to the State Agency (SA) an allegation of suspected narcotic drug diversion and misappropriation of property for 2 of 2 residents (R1 and R2). Finding include: Review of the 10/20/22 at 10:39 a.m., report to the State Agency (SA) identified the event had taken place on 10/15/22 at 5:30 a.m., when R2 reported she had not received oxycodone signed out in the narcotic book at 3:30 a.m. and 5:30 a.m. by LPN-C from the dates of 9/3/22 to 10/15/22. The report also identified R1 who was unable to verbalize pain and had symptoms of intractable pain when the LPN-C was on the schedule. Multiple staff had expressed concern regarding the LPN-C's behavior when working the night shift and would sign out narcotics and then go into the bathroom for an extended time. It was reported the LPN-C had a noticeable tremor at the beginning of his shift which disappeared by the end of his shift. R1's 8/10/22, Minimum Data Set (MDS) assessment identified R1 had severe cognitive impairment, total dependence for activities of daily living (ADLS), and no documented behavior. R1 received scheduled pain medication and demonstrated non-verbal indicators of pain. R1 had diagnoses which included anxiety disorder, contractures of upper and lower extremities, abnormal posture, anoxic brain damage, chronic pain syndrome, major depressive disorder,	F 609	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of	

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F 609	Continued From page 10 tracheostomy, dysphagia, muscle cramps and spasms, altered mental status, panic disorder, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). Review of her signed provider orders included a Fentanyl patch (a narcotic pain patch) 72 hour/25 micrograms (mcg) /hour (hr), Lorazepam 0.75 milligram (mg) via gastric tube (GT) four times daily (QID), oxycodone 5 mg GT-QID, citalopram 30 mg GT- every (Q) day (D), and ibuprofen 600 mg GT- QID. Review of medication administration record (MAR) for October and November identified documentation of pain medication administered as ordered with narcotic medication administered 7 out of 7 days. Review of the Narcotic log identified the Narcotic medications were accounted for and signed out as administered in both the handwritten Narcotic book and in the electronic record (PCC). Review of the 9/7/22 physician note identified R1 had chronic pain secondary to muscle contractures and was to have received scheduled pain medication in addition to as needed (PRN), orders for anxiety and discomfort. R1's current, undated care plan identified R1 had pain related to (r/t) spasticity, and contractures in multiple joints. R1 expressed pain non-verbally by grunting and facial grimacing along with crying and her face becoming red in appearance. Pain medications were to be administered as ordered and PRN when nonverbal signs/symptoms (s/s) of pain were observed. Staff were to monitor for side effects of pain medication and document	F 609	participation for the Medicaid and Medicare programs. On 11/3/2022-11/4/2022, MDH completed a standard abbreviated survey and noted the facility failed to timely report to the State Agency an allegation of suspected narcotic drug diversion and misappropriation of property for 2 of 2 residents. Administrator will review policies and procedures regarding reporting of all alleged abuse, neglect, or mistreatment. Allegations of abuse, neglect, or mistreatment will be reported to the state agency within two hours. Facility staff will report vulnerable adult incidents to Director of Nursing or Administrator via phone, not email. Administrator or designee will re-educate staff on the two-hour timeframe for reporting allegations of abuse, neglect, or mistreatment. Staff will be re-educated on the company policy and procedures surrounding such allegations. Audits will be conducted weekly for two months to ensure allegations of abuse, neglect, or mistreatment are reported within two hours. Results of the audits will be reviewed at QAPI for follow up and recommendations to ensure ONGOING compliance and those solutions are sustained. Deficiency to be corrected 12/9/2022. Director of Nursing or designee will be responsible to ensure compliance.	

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F 609	Continued From page 11 nonverbal and behavioral signs of pain such as facial grimacing, withdrawal, or guarding, aggression, agitation, or crying. R2's, 8/12/22 Quarterly, MDS identified her cognition was intact, she had mild depression and exhibited no behaviors. R2 was admitted with diagnoses which included heart failure, HTN, ESRD (renal insufficiency), diabetes, anxiety disorder, depression, morbid obesity, primary osteoarthritis left shoulder. R2 was to have scheduled and PRN pain medications including Tramadol 75 mg PO QID, and oxycodone 5 mg PO Q4H PRN. R2 received her scheduled medication PRN daily during the daytime hours when she was awake and active. R2's, Medication Administration Record (MAR), for October 2022 identified R2 received Oxycodone 26 of 31 days with pain rated at 9 or 10 of 10, during daytime hours, Tramadol 75 mg PO was scheduled and administered QID. The only Oxycodone administered during the overnight hours was documented by the LPN-C. Review of the 10/20/22 at 8:20 a.m., physician progress noted identified evaluation and discussion of R2's level of pain since 9/2/22. R2 indicated she had not needed/requested PRN pain medications as the Narcotic Book had indicated. R2 stated her pain level was not intractable, it had not prevented sleep or prevented her from attending activities. Her pain was currently stable and manageable per resident verbalization. Interview on 11/3/22 at 12:47 p.m., with licensed practical nurse (LPN)-A reported she did not recall the exact date, but stated it was a couple of	F 609		

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F 609	Continued From page 12 weeks ago, on a Friday night when the LPN-C came on duty at 6:30 p.m. and immediately went to his medication cart and started in the narcotic drawer where he began preparing R3's medications, took them to R3, returned and began preparing R1's medications, by placing her narcotic medication in one cup and regular medication in a second. LPN-A stated R1 was not due for any scheduled narcotics at that time. She stated she had gone to R1's room and began cares and LPN-C entered the room, with one medication cup, crushed the medications, cocktail'd them and administered via R1's G-tube. She reported the LPN-C competed the administration of R1's medications, walked out the door and immediately went into the bathroom. LPN-A stated while the LPN-C was in the bathroom, she had checked the narcotic book and R1's Ativan record had a dose signed out with a time of 9:05 p.m. and it was 7:00 p.m. When the LPN-C came out of the bathroom and joined her in a different resident room, she noted he had a bloody nose. When she commented on it, LPN-C became anxious and voiced excuses of dry air and allergies. LPN-A reported when the LPN-C went down the hall, she had rechecked the narcotic book to confirm what she had seen and stated she was going on break and telephoned the nurse manager (RN)-A to report what she had observed. RN-A instructed her to contact the DON to report her concerns, which she did. At about 8:05 p.m. LPN-A looked at the narcotic book and the time had been changed for R1's Ativan dose to 8:05 p.m. RN-A called back at about 9:00 p.m. to LPN-A to request an update and directed her to wait about 20-30 minutes and check R1 for any S/S that had not received her Ativan. LPN-A stated R1 was non-verbal and when she became upset, she would make a	F 609		

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F 609	Continued From page 13 squealing noise, become red and start crying. When LPN-A went into R1's room, she reported she had been displaying those S/S of agitation. LPN-A reported she had emailed the DON with a summary of what she had observed. LPN-A reported the following day she had observed the LPN-C repeat the same actions with medications. LPN-A stated when she had received shift report it was reported R1 had been upset and agitated most of the day following the 10/15/22 shift. LPN- A reported on 10/15/22, when LPN-B had come on duty for the afternoon shift he had come to her to ask how to handle a concern with the Narcotic book. LPN-B stated he had gone to talk with R2 prior to his shift and she had reported not receiving a dose of oxycodone that the LPN-C had supposedly administered to her that morning, and review of the Narcotic log for R2's oxycodone identified the LPN-C was the nurse that had signed out oxycodone for R2 on the morning of 10/15/22. LPN-A instructed LPN-B to notify the DON to report his concerns. Interview on 11/3/22 at 1:35 p.m., with LPN-B reported he had been the charge nurse on the weekend of 10/15/22 and 10/16/22 and had stopped to speak with R2 who told him about supposedly receiving an oxycodone at 5:30 a.m. the morning of 10/15/22, and it bothered her, but she had not received any medication at 5:30 a.m. on that morning. LPN-B reported he had retrieved the Narcotic log and the LPN-C was the only nurse that had made changes to times on 3 narcotic cards and the only nurse that administered R2's PRN oxycodone on the night shift. LPN-B repotted the logged times were exactly 4 hours LPN-Cart and he was the only nurse that had signed R2's oxycodone between	F 609		

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F 609	Continued From page 14 the times of 2:30 a.m.- 5-6:00 a.m., which LPN-B identified as unusual because R2 was usually sleeping during that time and did not complain of pain or request medication. LPN-B reported he was concerns and had made copies of the log and reviewed the administration of narcotics by LPN-C and it was noted to be taking place more frequently. LPN-B reported he was aware the LPN-C worked the 12-hour night shift and there was a rumor he had been suspected of similar conduct previously. Following the report by R2, LPN-B had looked at the assignment sheets and noted the LPN-C had supposedly administered the oxycodone to R2 at 2:30 a.m. and 5:30 a.m. on 10/15/22 and that was not the wing he had been assigned to work on. LPN-B had also questioned why the LPN-C had supposedly given her medication when he was not the nurse assigned to her wing on 10/15/22. Interview on 11/4/22 at 9:44 a.m., with the director of nursing (DON) reported R1 was in a semi-vegetative state and not able to verbalize her needs, so staff must anticipate and provide her needs. R1 can smile at times, and grunts with increased vocalization due to having a tracheostomy, but the level of sound she makes with facial expression is how staff determine pain. R1 was also observed to cry and became flushed when she had discomfort. The day after the reported incident, the DON reported she had assessed R1 and observed grunting, redness, and tears running down her face. The DON stated she had questioned staff and they reported that was how they were aware R1 was having pain. Interviewed staff reported they had observed indicators of pain, following a shift worked by the LPN-C and since he is no longer in facility the S/S had decreased. It was reported	F 609		

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F 609	Continued From page 15 when R1 received her scheduled medications for pain and anxiety her S/S were minimal, and she would relax and sleep. The DON stated she had received a call on the evening of 10/15/22 but was not concerned there was an issued until she returned to work on the morning of 10/17/22 and received the emails summarizing the concerns. At that time, she had begun her investigation and the LPN-C had been suspended pending the investigation and was removed from the schedule following the end of his shift on 10/16/22. During that interview with LPN-B, she reported she had left her medication keys on the desk when she had gone on break, and LPN-C had covered that unit when she was gone. Following the incident, education had been provided to nursing staff about leaving keys unattended, and if a nurse was working as an NA, they were not to have access to a medication cart, unless the nurse assigned to that unit asked for assistance. If the assigned nurse was going out of building the medication keys were to be given to the charge nurse or nurse manager for security. If a nurse was covering for a nurse leaving on break, and there was a need to administer a narcotic or PRN med they were required to update the assigned nurse, they were covering for and make a progress note. Review of the September 2022, Narcotic Management policy identified drug diversion was to be handled by the local police, the Office of Health Facility Complaints, and the Board of Nursing. The policy did not contain any actions to be completed by the facility if there was a suspicion of a drug diversion. Review of the July 2021, Vulnerable Adult-Abuse Prevention Plan policy identified all violations	F 609		

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F 609	Continued From page 16 involving abuse and/or misappropriation of resident property, are reported to the SA not later than 2 hours after the allegation is made. The policy identified Abuse as including not providing a resident goods or services that are necessary to avoid pain or mental anguish. An alleged violation was defined as a situation or occurrence that was observed and/or reported by staff, or other person and had not yet been investigated, but could result in abuse or misappropriation of resident property.	F 609		

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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: On 11/3/22 through 11/4/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52185296C (MN87827), with a licensing order issued at 1980. 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 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 not required at the bottom of the first page of state form.	2 000		

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	00770	A. BUILDING: _____ B. WING _____	C 11/04/2022

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2 000	Continued From page 2 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	21980		12/9/22

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21980	Continued From page 3 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 3 residents (R1 and R2), were free from misappropriation of property via drug diversion of ordered narcotic pain medication when licensed practical nurse (LPN)-C was found to have falsely noted giving the residents their pain medication. Findings include: Review of the 10/20/22 at 10:39 a.m., report to the State Agency (SA) identified the event had taken place on 10/15/22 at 5:30 a.m., when R2 reported she had not received oxycodone signed out in the narcotic book at 3:30 a.m. and 5:30 a.m. by LPN-C from the dates of 9/3/22 to 10/15/22. The report also identified R1 who was unable to verbalize pain and had symptoms of	21980	Submission of this Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of deficiencies was correctly cited and is also not to be construed as an admission against the Facility, Administrator, of any Employees, Agents or other individuals who draft or may be discussed in the Allegation of Compliance. In addition, preparation and submission of the Allegation of Compliance does not constitute an admission or an agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the Statement by the survey agency. Accordingly, the Facility has prepared and submitted this Allegation of Compliance solely because	

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21980	Continued From page 4 intractable pain when the LPN-C was on the schedule. Multiple staff had expressed concern regarding the LPN-C's behavior when working the night shift and would sign out narcotics and then go into the bathroom for an extended time. It was reported the LPN-C had a noticeable tremor at the beginning of his shift which disappeared by the end of his shift. R1's 8/10/22, Minimum Data Set (MDS) assessment identified R1 had severe cognitive impairment, total dependence for activities of daily living (ADLS), and no documented behavior. R1 received scheduled pain medication and demonstrated non-verbal indicators of pain. R1 had diagnoses which included anxiety disorder, contractures of upper and lower extremities, abnormal posture, anoxic brain damage, chronic pain syndrome, major depressive disorder, tracheostomy, dysphagia, muscle cramps and spasms, altered mental status, panic disorder, post-traumatic stress disorder (PTSD), and traumatic brain injury (TBI). Review of her signed provider orders included a Fentanyl patch (a narcotic pain patch) 72 hour/25 micrograms (mcg) /hour (hr), Lorazepam 0.75 milligram (mg) via gastric tube (GT) four times daily (QID), oxycodone 5 mg GT-QID, citalopram 30 mg GT- every (Q) day (D), and ibuprofen 600 mg GT- QID. Review of medication administration record (MAR) for October and November identified documentation of pain medication administered as ordered with narcotic medication administered 7 out of 7 days. Review of the Narcotic log identified the Narcotic medications were accounted for and signed out	21980	of the requirements under State and Federal law that mandate submission of an Allegation of Compliance within ten days of receipt of the Statement of Deficiencies as a condition of participation in Title 18 and Title 19 programs. The submission of this Allegation of Compliance within this timeframe should in no way be considered or construed as an agreement with allegations of noncompliance or admissions by the facility. This plan of correction is not to be construed as an admission by the facility or any of its agents that the survey agents findings in this report are true or correct. The plan of correction is written for the purpose of compliance with the rules of participation for the Medicaid and Medicare programs. On 11/3/2022-11/4/2022, MDH completed a standard abbreviated survey and noted the facility failed to timely report to the State Agency an allegation of suspected narcotic drug diversion and misappropriation of property for 2 of 2 residents. Administrator will review policies and procedures regarding reporting of all alleged abuse, neglect, or mistreatment. Allegations of abuse, neglect, or mistreatment will be reported to the state agency within two hours. Facility staff will report vulnerable adult incidents to Director of Nursing or Administrator via phone, not email. Administrator or designee will re-educate staff on the two-hour timeframe for reporting allegations of abuse, neglect, or mistreatment. Staff will be re-educated on	

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21980	Continued From page 5 as administered in both the handwritten Narcotic book and in the electronic record (PCC). Review of the 9/7/22 physician note identified R1 had chronic pain secondary to muscle contractures and was to have received scheduled pain medication in addition to as needed (PRN), orders for anxiety and discomfort. R1's current, undated care plan identified R1 had pain related to (r/t) spasticity, and contractures in multiple joints. R1 expressed pain non-verbally by grunting and facial grimacing along with crying and her face becoming red in appearance. Pain medications were to be administered as ordered and PRN when nonverbal signs/symptoms (s/s) of pain were observed. Staff were to monitor for side effects of pain medication and document nonverbal and behavioral signs of pain such as facial grimacing, withdrawal, or guarding, aggression, agitation, or crying. R2's, 8/12/22 Quarterly, MDS identified her cognition was intact, she had mild depression and exhibited no behaviors. R2 was admitted with diagnoses which included heart failure, HTN, ESRD (renal insufficiency), diabetes, anxiety disorder, depression, morbid obesity, primary osteoarthritis left shoulder. R2 was to have scheduled and PRN pain medications including Tramadol 75 mg PO QID, and oxycodone 5 mg PO Q4H PRN. R2 received her scheduled medication PRN daily during the daytime hours when she was awake and active. R2's, Medication Administration Record (MAR), for October 2022 identified R2 received Oxycodone 26 of 31 days with pain rated at 9 or 10 of 10, during daytime hours, Tramadol 75mg PO was scheduled and administered QID. The	21980	the company policy and procedures surrounding such allegations. Audits will be conducted weekly for two months to ensure allegations of abuse, neglect, or mistreatment are reported within two hours. Results of the audits will be reviewed at the Quality Assurance Committee for follow up and recommendations to ensure ongoing compliance and those solutions are sustained. Deficiency to be corrected 12/9/2022. Director of Nursing or designee will be responsible to ensure compliance.	

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21980	Continued From page 6 only Oxycodone administered during the overnight hours was documented by the LPN-C. Review of the 10/20/22 at 8:20 a.m., physician progress noted identified evaluation and discussion of R2's level of pain since 9/2/22. R2 indicated she had not needed/requested PRN pain medications as the Narcotic Book had indicated. R2 stated her pain level was not intractable, it had not prevented sleep or prevented her from attending activities. Her pain was currently stable and manageable per resident verbalization. Interview on 11/3/22 at 12:47 p.m., with licensed practical nurse (LPN)-A reported she did not recall the exact date, but stated it was a couple of weeks ago, on a Friday night when the LPN-C came on duty at 6:30 p.m. and immediately went to his medication cart and started in the narcotic drawer where he began preparing R3's medications, took them to R3, returned and began preparing R1's medications, by placing her narcotic medication in one cup and regular medication in a second. LPN-A stated R1 was not due for any scheduled narcotics at that time. She stated she had gone to R1's room and began cares and LPN-C entered the room, with one medication cup, crushed the medications, cocktailed them and administered via R1's G-tube. She reported the LPN-C competed the administration of R1's medications, walked out the door and immediately went into the bathroom. LPN-A stated while the LPN-C was in the bathroom, she had checked the narcotic book and R1's Ativan record had a dose signed out with a time of 9:05 p.m. and it was 7:00 p.m. When the LPN-C came out of the bathroom and joined her in a different resident room, she noted he had a bloody nose. When she commented on	21980		

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21980	Continued From page 7 it, LPN-C became anxious and voiced excuses of dry air and allergies. LPN-A reported when the LPN-C went down the hall, she had rechecked the narcotic book to confirm what she had seen and stated she was going on break and telephoned the nurse manager (RN)-A to report what she had observed. RN-A instructed her to contact the DON to report her concerns, which she did. At about 8:05 p.m. LPN-A looked at the narcotic book and the time had been changed for R1's Ativan dose to 8:05 p.m. RN-A called back at about 9:00 p.m. to LPN-A to request an update and directed her to wait about 20-30 minutes and check R1 for any S/S that had not received her Ativan. LPN-A stated R1 was non-verbal and when she became upset, she would make a squealing noise, become red and start crying. When LPN-A went into R1's room, she reported she had been displaying those S/S of agitation. LPN-A reported she had emailed the DON with a summary of what she had observed. LPN-A reported the following day she had observed the LPN-C repeat the same actions with medications. LPN-A stated when she had received shift report it was reported R1 had been upset and agitated most of the day following the 10/15/22 shift. LPN- A reported on 10/15/22, when LPN-B had come on duty for the afternoon shift he had come to her to ask how to handle a concern with the Narcotic book. LPN-B stated he had gone to talk with R2 prior to his shift and she had reported not receiving a dose of oxycodone that the LPN-C had supposedly administered to her that morning, and review of the Narcotic log for R2's oxycodone identified the LPN-C was the nurse that had signed out oxycodone for R2 on the morning of 10/15/22. LPN-A instructed LPN-B to notify the DON to report his concerns.	21980		

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21980	Continued From page 8 Interview on 11/3/22 at 1:35 p.m., with LPN-B reported he had been the charge nurse on the weekend of 10/15/22 and 10/16/22 and had stopped to speak with R2 who told him about supposedly receiving an oxycodone at 5:30 a.m. the morning of 10/15/22, and it bothered her, but she had not received any medication at 5:30 a.m. on that morning. LPN-B reported he had retrieved the Narcotic log and the LPN-C was the only nurse that had made changes to times on 3 narcotic cards and the only nurse that administered R2's PRN oxycodone on the night shift. LPN-B repotted the logged times were exactly 4 hours LPN-Cart and he was the only nurse that had signed R2's oxycodone between the times of 2:30 a.m.- 5-6:00 a.m., which LPN-B identified as unusual because R2 was usually sleeping during that time and did not complain of pain or request medication. LPN-B reported he was concerns and had made copies of the log and reviewed the administration of narcotics by LPN-C and it was noted to be taking place more frequently. LPN-B reported he was aware the LPN-C worked the 12-hour night shift and there was a rumor he had been suspected of similar conduct previously. Following the report by R2, LPN-B had looked at the assignment sheets and noted the LPN-C had supposedly administered the oxycodone to R2 at 2:30 a.m. and 5:30 a.m. on 10/15/22 and that was not the wing he had been assigned to work on. LPN-B had also questioned why the LPN-C had supposedly given her medication when he was not the nurse assigned to her wing on 10/15/22. Interview on 11/4/22 at 9:44 a.m., with the director of nursing (DON) reported R1 was in a semi-vegetative state and not able to verbalize her needs, so staff must anticipate and provide her needs. R1 can smile at times, and grunts	21980		

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21980	Continued From page 9 with increased vocalization due to having a tracheostomy, but the level of sound she makes with facial expression is how staff determine pain. R1 was also observed to cry and became flushed when she had discomfort. The day after the reported incident, the DON reported she had assessed R1 and observed grunting, redness, and tears running down her face. The DON stated she had questioned staff and they reported that was how they were aware R1 was having pain. Interviewed staff reported they had observed indicators of pain, following a shift worked by the LPN-C and since he is no longer in facility the S/S had decreased. It was reported when R1 received her scheduled medications for pain and anxiety her S/S were minimal, and she would relax and sleep. The DON stated she had received a call on the evening of 10/15/22 but was not concerned there was an issued until she returned to work on the morning of 10/17/22 and received the emails summarizing the concerns. At that time, she had begun her investigation and the LPN-C had been suspended pending the investigation and was removed from the schedule following the end of his shift on 10/16/22. During that interview with LPN-B, she reported she had left her medication keys on the desk when she had gone on break, and LPN-C had covered that unit when she was gone. Following the incident, education had been provided to nursing staff about leaving keys unattended, and if a nurse was working as an NA, they were not to have access to a medication cart, unless the nurse assigned to that unit asked for assistance. If the assigned nurse was going out of building the medication keys were to be given to the charge nurse or nurse manager for security. If a nurse was covering for a nurse leaving on break, and there was a need to administer a narcotic or PRN med they were required to update the assigned	21980		

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21980	Continued From page 10 nurse, they were covering for and make a progress note. Review of the September 2022, Narcotic Management policy identified drug diversion was to be handled by the local police, the Office of Health Facility Complaints, and the Board of Nursing. The policy did not contain any actions to be completed by the facility if there was a suspicion of a drug diversion. Review of the July 2021, Vulnerable Adult-Abuse Prevention Plan policy identified all violations involving abuse and/or misappropriation of resident property, are reported to the SA not later than 2 hours after the allegation is made. The policy identified Abuse as including not providing a resident goods or services that are necessary to avoid pain or mental anguish. An alleged violation was defined as a situation or occurrence that was observed and/or reported by staff, or other person and had not yet been investigated, but could result in abuse or misappropriation of resident property. F609 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after	21980		

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21980	Continued From page 11 compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		