Minnesota
Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Lyngblomsten Care Center			**Report Number:** H5347080	**Date of Visit:** July 12 and 13, 2016
Facility Address: 1415 Almond Avenue			**Time of Visit:** 8:15 a.m. - 4:45 p.m. 8:00 a.m. - 2:45 p.m.	**Date Concluded:** November 7, 2016
Facility City: St. Paul			**Investigator's Name and Title:** Jane Aandal, RN and Arthur Biah, RN	
State: Minnesota	**ZIP:** 55108	**County:** Ramsey		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was financially exploited when alleged perpetrator took resident's pain medications.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the the alleged perpetrator (AP) took narcotic pain medications from multiple residents several times.

A physician ordered hydrocodone/acetaminophen (a opioid/narcotic pain medication) 5/325 milligrams (mg) every four hours as needed for the resident's moderate to severe breakthrough pain. The facility staff administered the resident's medications.

At approximately 9:30 p.m., the resident requested prescribed pain medication and the nurse went to retrieve the medication from an automated medication dispensing machine. The nurse entered his/her identification and password to retrieve the medication and the dispensing machine indicated it was "too early." The nurse informed the supervisor, who contacted the pharmacy that services the medication dispensing machine. The pharmacy was able to tell the supervisor the AP had retrieved the pain medication for the resident at 7:12 p.m. The AP was working that evening on another unit and was not assigned to the resident. The supervisor spoke with the AP. The AP did not have a clear explanation.

The video surveillance in the medication room identified the AP entering the room, accessing the machine at 7:12 p.m., and placing the medication envelope in his/her right uniform pocket. A machine report verified the AP was the person who retrieved medication for the resident. The transaction report from the machine indicated the AP had retrieved the resident's pain medication 73 times over a four month period. The AP

had not documented any of the medications were given to the resident on the electronic medication administration record.

The resident was interviewed and stated s/he was having tooth pain that evening and requested the pain medication. The resident was given plain acetaminophen for pain relief.

Additional documentation review and staff interviews were conducted during the investigation. The AP retrieved narcotic pain medication from the medication dispensing machine for six residents from January 2016 to April 2016, retrieving a total of 350 opioid tablets. The AP did not document these tablets as administered to the six residents on the electronic medication administration record. S/he reported s/he had forgotten to document.

The police report indicated the AP admitted to taking one to two Oxycodone HCL (another opioid narcotic) 5 mg tablets from residents during five separate incidents over a four month period of time. In addition, the police searched the AP's purse and found six opioid tablets that the AP admitted belonged to other residents at the facility. The case was forwarded to the county attorney for charges.

During an interview, the AP reported s/he had taken one or two Oxycodone HCL 5 mg tablets from a resident during five separate incidents over a four month period. The AP sated s/he did not give medication to the resident on the evening of the incident. The AP indicated the tablets, found by the police in his/her purse, did not come from the facility.

After the video surveillance confirmed the AP's conduct, s/he was terminated from the facility.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☐ Neglect ☒ Financial Exploitation. This determination was based on the following:

The facility is responsible because it lacked a policy and procedure to periodically reconcile narcotic medications retrieved from the Passport medication dispensing machine. The AP is responsible because the facility had policies in place related to financial exploitation which the nurse was trained on.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(b) In the absence of legal authority a person:

(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of

maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Physician Orders
- [x] Other, specify:

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Personnel Records/Background Check, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: five

Were residents selected based on the allegation(s)? (●) Yes ( ) No ( ) N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

(●) Yes ( ) No ( ) N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ( ) Yes ( ) No (●) N/A

Specify: Facility Report

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: (●) Yes ( ) No ( ) N/A Specify:

Did you interview the resident(s) identified in allegation:

(●) Yes ( ) No ( ) N/A Specify:

Did you interview additional residents? (●) Yes ( ) No

Total number of resident interviews: four

Interview with staff: (◉) Yes ( ) No ( ) N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: (◉) Yes ( ) No

Total number of staff interviews: nine

Physician Interviewed: ( ) Yes (◉) No

Nurse Practitioner Interviewed: ( ) Yes (◉) No

Physician Assistant Interviewed: ( ) Yes (◉) No

Interview with Alleged Perpetrator(s): (◉) Yes ( ) No ( ) N/A Specify:

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued ( ) No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

Observations were conducted related to:

☒ Nursing Services

☒ Facility Tour

☒ Other: Narcotic Count

Was any involved equipment inspected: ( ) Yes ( ) No (◉) N/A

Was equipment being operated in safe manner: ( ) Yes ( ) No (◉) N/A

Were photographs taken: ( ) Yes (◉) No Specify:

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

Minnesota Board of Pharmacy

The Office of Ombudsman for Long-Term Care

St. Paul Police Department

Ramsey County Attorney

St. Paul City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING ____ B. WING ____	C 11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE SAINT PAUL, MN 55108**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5347080. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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

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 431	Continued From page 1 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure licensed nursing staff documented on the electronic medication administration record when administering as needed (PRN) narcotic medications according to facility policy for 6 of 6 residents reviewed (R1, R2, R3, R4, R5 and R6). Findings include: R1's medical record was reviewed. R1 was cognitively intact diagnosed with a stroke and osteoarthritis. R1 had a physician order from January through April 2016 for Hydrocodone-Acetaminophen (Norco, a narcotic pain medication) 5/325 milligrams (mg) 1 tablet every four hours as needed prn for moderate to severe breakthrough pain. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 18 times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.	F 431		

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F 431	Continued From page 2 The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 17 times in February 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 16 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 22 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. R2's medical record was reviewed. R2 was diagnosed with osteoarthritis and knee pain. R2 had a physician order from January through April 2016 for Oxycodone HCL 10 mg (5 mg tablets) twice daily as needed. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 34 times in January 2016,	F 431		

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for a total of 68 tablets and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 18 times in February 2016, for a total of 36 tablets and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 19 times in March 2016, for a total of 38 tablets and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 20 times in April 2016, and documented once on the electronic medication administration record for a total of 38 tablets not documented on the electronic medication administration record.

R3's medical record was reviewed. R3 was diagnosed with severe headaches.

R3 had a physician order for January through

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April 2016 for Oxycodone HCL 5 mg twice daily as needed.

The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg ten times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg eight times in February 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg 14 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg 13 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

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F 431	Continued From page 5 R4's medical record was reviewed. R4 was diagnosed with a pathological fracture. R4 had a physician order for January 2016 for Oxycodone HCL 5 mg every four hours as needed. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R4's Oxycodone four times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. R5's medical record was reviewed. R5 was diagnosed with osteoarthritis and back pain. R5 had a physician order for January through April 2016 for Oxycodone HCL 5 mg every six hours as needed. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg nine times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg ten times in February 2016, and did not document the administration of any of the medications accessed on the	F 431		

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F 431	Continued From page 6 electronic medication administration record. The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg 12 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg 12 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. R6's medical record was reviewed. R6 was diagnosed with chronic low back pain. R6 had a physician order for March and April 2016 for Oxycodone HCL 5 mg every six hours as needed. The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R6's Oxycodone HCL 5 mg one time in March 2016, and did not document the medication accessed on the electronic medication administration record. The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed	F 431		

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practical nurse (LPN)-F accessed R6's Oxycodone HCL four times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

LPN-F accessed narcotic pain medications from the medication dispensing machine called Passport for R1, R2, R3, R4, R5 and R6 from January to April 2016. LPN-F retrieved a total of 350 narcotic tablets that she did not document as administered to R1, R2, R3, R4, R5 and R6 on the electronic medication administration record.

An interview with the director of nursing (DON) was conducted on 7/12/16, at 8:17 a.m. The DON stated it was determined during the internal investigation that LPN-F had a pattern of taking as needed medications for residents that were not documented on the electronic medication administration record. The DON stated when he interviewed LPN-F she stated she had forgotten to document the as needed medications for the residents.

An interview with R1 was conducted on 7/12/16, at 10:02 a.m. R1 stated there was an evening when she had requested Norco medication for pain as she had a decayed tooth that was going to be pulled. R1 stated LPN-B informed her they were having problems with the Passport machine and she was offered Tylenol which was effective.

An interview was conducted with licensed practical nurse (LPN)-B on 7/12/16, at 3:55 p.m. LPN-B stated on 4/29/16, on the evening shift R1 had requested Norco for tooth pain. LPN-B stated when she logged into the Passport medication machine and requested a Norco pain medication

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for R1, the screen displayed a message that read, "To early." LPN-B stated she thought she had logged into the Passport machine incorrectly so she tried again with no success. LPN-B then reported to her supervisor registered nurse (RN)-C. LPN-B then offered Tylenol 1000 mg to R1 which was effective for the tooth pain.

An interview was conducted with RN-C on 7/12/16, at 4:28 p.m. RN-C stated LPN-B had notified her on 4/29/16, in the evening that she was unable to access a Norco pain medication for R1 from the Passport machine. RN-C stated she called the pharmacy who serviced the Passport machine. RN-C found out that LPN-F had accessed the Norco for R1 around 7:30 p.m. RN-C then spoke to LPN-F who was working on another unit who stated maybe she had stayed logged into the Passport machine. LPN-F then called RN-C back and told her she did not know how that could have happened. RN-C informed LPN-F there was video surveillance in the Passport room. RN-C stated it would not be normal for a nurse to access pain medication for a resident on another unit. RN-C stated she called LPN-E (administrative nurse) who stated she would be in early on 4/30/16.

An interview was conducted with LPN-E on 7/13/16, at 10:52 a.m. LPN-E stated on 4/29/16, at approximately 9:50 a.m. she received a call from RN-C relaying that LPN-B was unable to access a Norco pain medication for R1. LPN-E stated she logged into the Passport machine on 4/30/16, at approximately 8:25 a.m. and reviewed the prn medications dispensed to R1 from 4/11/16, through 4/30/16 which had LPN-F's initials. LPN-E compared that information to R1's electronic medication administration record and

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noted that LPN-F had accessed 16 doses of Norco that were not documented on the electronic medication administration record for R1.

On 7/13/16, at 12:59 p.m. the Passport room was observed to have a keypad outside the door. LPN-E entered the room and stated each time someone enters the Passport room their identification is logged by the pharmacy. LPN-E stated there was a camera on at all times in the Passport room and the nurse must access the machine with their name and password.

An interview was conducted with LPN-F on 7/25/16, at 10:08 a.m. LPN-F stated she did take pain medications from a resident back in January 2016, which was Oxycodone HCL 5 mg one or two tablets for her own personal use. LPN-F stated she did not give medication to R1 on 4/29/16, as she was working on another unit.

The facility lacked a controlled substance policy which would reconcile narcotic medications accessed from the Passport machine against the electronic medication administration record to minimize the risk of drug diversion.

The facility's oral medication administration procedure revised 10/15, indicated immediately after administration complete documentation in the electronic medication administration record indicating the medication was given.

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2 000	Initial Comments	2 000		

*****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:
A complaint investigation was conducted to investigate complaint #H5347080. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 760	MN Rule 4658.0505 F. Responsibilities; DNS; Assiging, supervising, The written job description for the director of nursing services must include responsibility for: F. assigning, supervising, and evaluating the performance of all nursing personnel; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an annual performance appraisal was completed for 4 of 4 licensed practical nurses (LPN) and 3 of 3 registered nurses (RN) reviewed that addressed the quality of care provided to residents. This had the potential to affect 231 residents. Findings include: LPN-F was hired on 6/12/14. The personnel file indicated LPN-F had not had an annual employee evaluation completed. RN-K was hired on 7/26/04. The personnel file indicated RN-K's employee evaluation was last	2 760		

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2 760	Continued From page 2 completed on 1/10/07. LPN-L was hired on 10/11/99. The personnel file indicated LPN-L's employee evaluation was last completed on 1/30/14. RN-M was hired on 3/8/04. The personnel file indicated RN-M's employee evaluation was last completed on 6/6/06. LPN-N was hired on 12/13/04. The personnel file indicated LPN-N's employee evaluation was last completed on 2/11/12. LPN-O was hired on 10/23/95. The personnel file indicated LPN-O's employee evaluation was last completed on 9/24/14. RN-P was hired on 6/21/08. The personnel file indicated RN-P's employee evaluation was last completed on 11/7/13. An interview was conducted with the human resource (HR) director on 7/13/16, at 2:22 p.m. The HR director stated normally employee evaluations would be completed by the employee's supervisor after three months of employment and annually thereafter. The HR department would normally send a list to the supervisory staff monthly with the employee names due for an evaluation. However, the completed evaluations were never returned to the HR department. The HR director stated it was the responsibility of the department and nursing to ensure the evaluations were completed. An interview was conducted with the director of nursing (DON) on 7/12/16, at 8:46 a.m. The DON stated the policy was for nurses to be evaluated annually.	2 760		

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2 760	Continued From page 3 An interview was conducted with the DON on 7/13/16, at 2:38 p.m. The DON stated he was not aware the employee evaluations had not been done for such a long time. The Lyngblomsten Employee Handbook revised 11/05, indicated evaluations were usually completed by the employee's supervisor after the three months training period and on the anniversary date of employment each year. SUGGESTED METHOD OF CORRECTION: The human resource (HR) director along with the director of nursing (DON) could review the employee handbook with the supervisory staff regarding employee evaluations. The HR director could establish a system to ensure all employee evaluations were completed timely. The quality assessment and assurance committee could implement monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 760		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as	21850		

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authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure residents were free from maltreatment of financial exploitation for 6 of 6 residents (R1, R2, R3, R4, R5 and R6) whose medications were taken by licensed practical nurse (LPN)-F for her own personal use.

Findings include:

R1's medical record was reviewed. R1 was cognitively intact diagnosed with a stroke and osteoarthritis.

R1 had a physician order from January through April 2016 for Hydrocodone-Acetaminophen (Norco, a narcotic pain medication) 5/325 milligrams (mg) 1 tablet every four hours as needed prn for moderate to severe breakthrough pain.

The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 18 times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated February 2016, was reviewed and

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compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 17 times in February 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 16 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R1's Norco 5/325 mg 22 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

R2's medical record was reviewed. R2 was diagnosed with osteoarthritis and knee pain.

R2 had a physician order from January through April 2016 for Oxycodone HCL 10 mg (5 mg tablets) twice daily as needed.

The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 34 times in January 2016, for a total of 68 tablets and did not document the administration of any of the medications accessed on the electronic medication

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administration record.

The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 18 times in February 2016, for a total of 36 tablets and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 19 times in March 2016, for a total of 38 tablets and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R2's Oxycodone HCL 10 mg 20 times in April 2016, and documented once on the electronic medication administration record for a total of 38 tablets not documented on the electronic medication administration record.

R3's medical record was reviewed. R3 was diagnosed with severe headaches.

R3 had a physician order for January through April 2016 for Oxycodone HCL 5 mg twice daily as needed.

The electronic medication administration record

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dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg ten times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg eight times in February 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg 14 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R3's Oxycodone HCL 5 mg 13 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record.

R4's medical record was reviewed. R4 was diagnosed with a pathological fracture.

R4 had a physician order for January 2016 for Oxycodone HCL 5 mg every four hours as

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21850	Continued From page 8 needed. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R4's Oxycodone four times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. R5's medical record was reviewed. R5 was diagnosed with osteoarthritis and back pain. R5 had a physician order for January through April 2016 for Oxycodone HCL 5 mg every six hours as needed. The electronic medication administration record dated January 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg nine times in January 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated February 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg ten times in February 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's	21850		

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21850	Continued From page 9 Oxycodone HCL 5 mg 12 times in March 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R5's Oxycodone HCL 5 mg 12 times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. R6's medical record was reviewed. R6 was diagnosed with chronic low back pain. R6 had a physician order for March and April 2016 for Oxycodone HCL 5 mg every six hours as needed. The electronic medication administration record dated March 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R6's Oxycodone HCL 5 mg one time in March 2016, and did not document the medication accessed on the electronic medication administration record. The electronic medication administration record dated April 2016, was reviewed and compared to the Passport Transaction Report. Licensed practical nurse (LPN)-F accessed R6's Oxycodone HCL four times in April 2016, and did not document the administration of any of the medications accessed on the electronic medication administration record. LPN-F accessed narcotic pain medications from	21850		

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21850	Continued From page 10 the medication dispensing machine called Passport for R1, R2, R3, R4, R5 and R6 from January to April 2016. LPN-F retrieved a total of 350 narcotic tablets that she did not document as administered to R1, R2, R3, R4, R5 and R6 on the electronic medication administration record. An interview with the director of nursing (DON) was conducted on 7/12/16, at 8:17 a.m. The DON stated it was determined during the internal investigation that LPN-F had a pattern of taking as needed medications for residents that were not documented on the electronic medication administration record. The DON stated when he interviewed LPN-F she stated she had forgotten to document the as needed medications for the residents. An interview with R1 was conducted on 7/12/16, at 10:02 a.m. R1 stated there was an evening when she had requested Norco medication for pain as she had a decayed tooth that was going to be pulled. R1 stated LPN-B informed her they were having problems with the Passport machine and she was offered Tylenol which was effective. An interview was conducted with licensed practical nurse (LPN)-B on 7/12/16, at 3:55 p.m. LPN-B stated on 4/29/16, on the evening shift R1 had requested Norco for tooth pain. LPN-B stated when she logged into the Passport medication machine and requested a Norco pain medication for R1, the screen displayed a message that read, "To early." LPN-B stated she thought she had logged into the Passport machine incorrectly so she tried again with no success. LPN-B then reported to her supervisor registered nurse (RN)-C. LPN-B then offered Tylenol 1000 mg to R1 which was effective for the tooth pain.	21850		

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21850	Continued From page 11 An interview was conducted with RN-C on 7/12/16, at 4:28 p.m. RN-C stated LPN-B had notified her on 4/29/16, in the evening that she was unable to access a Norco pain medication for R1 from the Passport machine. RN-C stated she called the pharmacy who serviced the Passport machine. RN-C found out that LPN-F had accessed the Norco for R1 around 7:30 p.m. RN-C then spoke to LPN-F who was working on another unit who stated maybe she had stayed logged into the Passport machine. LPN-F then called RN-C back and told her she did not know how that could have happened. RN-C informed LPN-F there was video surveillance in the Passport room. RN-C stated it would not be normal for a nurse to access pain medication for a resident on another unit. RN-C stated she called LPN-E (administrative nurse) who stated she would be in early on 4/30/16. An interview was conducted with LPN-E on 7/13/16, at 10:52 a.m. LPN-E stated on 4/29/16, at approximately 9:50 a.m. she received a call from RN-C relaying that LPN-B was unable to access a Norco pain medication for R1. LPN-E stated she logged into the Passport machine on 4/30/16, at approximately 8:25 a.m. and reviewed the prn medications dispensed to R1 from 4/11/16, through 4/30/16 which had LPN-F's initials. LPN-E compared that information to R1's electronic medication administration record and noted that LPN-F had accessed 16 doses of Norco that were not documented on the electronic medication administration record for R1. On 7/13/16, at 12:59 p.m. the Passport room was observed to have a keypad outside the door. LPN-E entered the room and stated each time someone enters the Passport room their	21850		

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identification is logged by the pharmacy. LPN-E stated there was a camera on at all times in the Passport room and the nurse must access the machine with their name and password.

An interview was conducted with LPN-F on 7/25/16, at 10:08 a.m. LPN-F stated she did take pain medications from a resident back in January 2016, which was Oxycodone HCL 5 mg one or two tablets for her own personal use. LPN-F stated she did not give medication to R1 on 4/29/16, as she was working on another unit.

The facility's Vulnerable Adult Abuse Prevention Policy revised 3/15, indicated Lyngblomsten Care Center did not tolerate any forms of physical abuse, verbal abuse, sexual abuse, mental abuse, neglect, corporal punishment, involuntary seclusion, or misappropriation of resident property by anyone.

The facility lacked a controlled substance policy which would reconcile narcotic medications accessed from the Passport machine against the EMAR to minimize the risk of drug diversion.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could implement a system to ensure pain medications were documented on the electronic medication administration record when administered. The DON could establish an auditing system for the Passport machine against the electronic medication administration record related to narcotic usage. The DON could provide vulnerable adult training to all nursing staff. The quality assessment and assurance committee could implement monitoring to ensure compliance.

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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) COMPLETE DATE
21850	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245347 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00501 Y1	A. Building B. Wing Y2	12/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20760 Reg. # MN Rule 4658.0505 F. LSC	Correction Completed 12/17/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 12/17/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/7/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			