DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Cerenity Care Center Marian

Facility Address:
200 Earl Street

Facility City:
St. Paul

State:	**ZIP:**	**County:**
Minnesota	55106	Ramsey

Report Number:
H5365024, H5365025, and H5365026

Date of Visit:
March 27 and 28, 2017

Time of Visit:
8:30 a.m. to 4:00 p.m.
8:30 a.m. to 2:00 p.m.

Date Concluded:
December 29, 2017

Investigator's Name and Title:
Jessica Sellner, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was financially exploited when staff/alleged perpetrator signed out narcotics for the residents but never administered it.

☒ 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 alleged perpetrator (AP) stole resident's as needed (PRN) narcotic medication. The AP documented administering PRN narcotic medication to three residents, however, all three resident's stated they did not receive or request additional PRN narcotic medication and were not experiencing any increase in pain. In addition, through the investigation it was discovered that two other resident's had PRN narcotic medication documented in the narcotic book as removed by the AP; however, there was no documentation the AP administered the narcotic to the resident's.

Resident's #1, #2, #3, #4, #5, and #6 all had physician ordered PRN narcotic medication for pain control.

Resident #1's narcotic record indicated during one of the AP's 8 hour shift s/he removed Oxycodone 5 mg at 10:20 a.m., 12:00 p.m., and 3:00 p.m. There was also another Oxycodone 5 mg removed the same day, however, there was no time. Written next to the signature of the AP by the Oxycodone in the narcotic book was the word, "wasted," and another staff's initials next to it. The resident's medication administration record (MAR) indicated the AP gave the 4:00 p.m. dose of Oxycodone 5 mg to the resident at 2:28 p.m.,

"Due to condition." Resident #1's MAR indicated on the same day, the AP contacted Resident #1's physician and requested a one time PRN order for Oxycodone 10 mg orally, to administer to Resident #1 prior to a treatment. The AP indicated on Resident #1's MAR the Oxycodone 10 mg was given to Resident #1 at 12:00 p.m.

The facility investigation indicated the AP stated s/he contacted the on-call physician and obtained a one time order for Oxycodone 10 mg to be given to Resident #1 for increased pain. The AP stated the same day s/he wasted a dose of Oxycodone after removing it from the narcotic box because s/he realized it was too soon to give Resident #1 another dose. The AP stated another staff member witnessed the destruction of the Oxycodone which was disposed of in the sharps container. The facility contacted the on-call physician and there was no record the AP contacted the physician for an additional dose of Oxycodone 10 mg for Resident #1. Resident #1's medical record contained no documentation of increased pain, and Resident #1 denied requesting or receiving additional doses of Oxycodone. The facility removed the only pill from the sharps container which was identified as Lasix (a water pill). The staff member who signed off the destruction of the Oxycodone stated s/he did not see the actual destruction of the medication and signed off on the destruction per the AP's request.

The AP documented in the narcotic book that Resident #2's Oxycodone 5 mg was removed at 10:00 a.m and at 1:00 p.m. The 10:00 a.m. entry was crossed out with a line drawn through it. There was no corresponding documentation regarding the 10:00 a.m. Oxycodone the AP removed.

The facility investigation indicated the AP stated after removing the 10:00 a.m. Oxycodone s/he realized it was too soon to administer so s/he wasted it with another staff member by disposing of it in the sharps container. The only pill in the sharps container was identified as Lasix. The staff member who signed off the destruction of the Oxycodone stated s/he did not see the actual destruction of the medication and signed off on the destruction per the AP's request. The resident stated s/he did not request or receive additional pain medication.

Resident #3's MAR indicated in 44 days, Oxycodone 5 mg PRN was administered a total of eight times. All eight doses were documented as administered by the AP. Resident #3's medical record contained only three corresponding progress notes when PRN Oxycodone was administered by the AP which indicated Resident #3 had generalized pain, arm pain, and/ or neck pain. Resident #3's medical record contained no further documentation from any other staff indicating Resident #3 had any signs or symptoms of pain.

Resident #4's MAR indicated in one month Resident #4 received five doses of PRN Oxycodone, all documented as administered by the AP. The MAR indicated the AP removed PRN Oxycodone 5 mg at 6:34 p.m. and 10:20 p.m. Resident #4's narcotic record indicated on the same day the AP removed PRN Oxycodone 5 mg on at 6:30 p.m., 9:00 p.m., and 10:00 p.m. There was no documentation regarding the additional dose of Oxycodone removed, and Resident #4's MAR indicated Resident #4 only received two PRN Oxycondone administered by the AP.

Resident #5's progress note written by another nurse indicated Resident #5 was not having any pain, however, the AP had signed out in the narcotic book administering three doses of PRN Oxycondone to

Resident #5 the prior evening.

Resident #6's MAR indicated in one month Resident #6 received six PRN doses of Oxycodone, three were administered by the AP. Resident #6's narcotic record indicated in that month the AP removed Oxycodone 2.5 mg five times. There was no corresponding documentation regarding the additional two Oxycondone removed and not administered to Resident #6.

When interviewed, Resident #1 denied requesting or receiving additional doses of his/her narcotic pain medication.

When interviewed, the AP stated the other nurse's at the facility did not recognize resident pain and keeping the resident's pain under control was a priority for her/him. The AP stated although it appeared s/he was administering more narcotic medication than other staff, s/he was using nursing judgment. The AP stated after the facility questioned her/him for a third time about the excessive narcotic administration and inconsistency in the medication counts, s/he quit working at the facility. The AP was unable to explain the inconsistency's in the resident records reviewed for narcotic administration.

When interviewed, the facility management stated they had concerns for approximately the past seven months about the AP's excessive PRN narcotic medication administration to residents. The facility management stated they noted the AP was signing out PRN narcotic medication for multiple residents who generally did not complain of pain or request PRN pain medication. The AP was spoken to regarding the concerns of excessive PRN administration on three separate occasions in the previous seven months and developed a performance improvement plan. The performance improvement plan directed the AP to have another nurse assess the resident's need for pain medication and document their findings prior to the AP administering any PRN narcotic medication to a resident. The AP did not follow the performance improvement plan and the facility was not monitoring the AP to ensure compliance with the plan.

The facility contacted law enforcement who are also investigating.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 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 AP documented removing resident narcotics, however, there was no corresponding documentation the

narcotic was administered to the resident. The AP was unable to provide a physician order for the additional Oxycodone. The resident's who did not have any recent history of pain received PRN narcotic medication from only the AP with no corresponding documentation regarding a change in the resident's pain. The facility had previous concerns about the AP's excessive narcotic administration, however, the facility failed to put systems in place to prevent further financial exploitation from occurring.

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:

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 Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) 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:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the 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] Care Guide
- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Activities Reports

- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan
- [x] Other, specify:

Other pertinent medical records:

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Call Light Audits
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: 11

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, 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: Resident #1

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:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Restorative Care
☒ Transfers
☒ Facility Tour
☒ Injury

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
	245365	A. BUILDING _____ B. WING _____	R-C 12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	**200 EARL STREET SAINT PAUL, MN 55106**

(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 A Post Certification revisit was conducted on 12/11/2017, to follow up on deficiencies issued related to complaint H5365024, H5365025, and H5365026. Cerenity Care Center - Marian is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/13/2017

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	R-C 12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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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: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5365024, H5365025, and H5365026. Cerenity Care Center - Marian was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

Minnesota Department of Health

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{2 000}	Continued From page 1 signature is not required at the bottom of the first page of the state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 10/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Surveyor: 29249 An abbreviated standard survey was conducted to investigate case #H5365024, H5365025, and H5365026. As a result, the following deficiency is issued related to case #H5365024, H5365025, and H5365026. 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	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		11/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	C 10/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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F 431	Continued From page 1 that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 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: Surveyor: 29249 Based on interview and document review, the facility failed to ensure every administration of a narcotic medication was documented on the medication administration record (MAR) to ensure accurate reconciliation of controlled medications and minimize potential drug diversion for 5 of 11 residents reviewed, R1, R2, R3, R10, and R11, who had a narcotic record indicated narcotic medication was removed,	F 431	Cerenity Care Center Marian of Saint Paul s Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly sited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or	

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F 431	Continued From page 2 however, there was no corresponding documenting in the resident's medical record indicating they received the narcotic medication. Findings include: R1's physician orders dated 3/27/17, included Oxycodone 5 mg tablet three times a day for pain, and Oxycodone 5 mg tablet every 6 hours as needed (PRN) for pain. R1's narcotic record indicated on 1/29/17, at 11:00 a.m. Registered Nurse (RN)-I removed Oxycodone 5 mg for R1. Written in the narcotic book next to RN-I signature was "wasted." Trained Medication Assistant (TMA)-C initialed next to RN-I's initials. There was no corresponding documentation why the Oxycodone was removed and not administered. R1's narcotic record indicated on 2/13/17, RN-I removed Oxycodone 5 mg at 10:20 a.m., 12:00 p.m., and 3:00 p.m. There was also another Oxycodone 5 mg removed dated 2/13/17, however, there was no time. Written next to the signature of RN-I and TMA-C was "wasted." R1's MAR indicated on 2/13/17, RN-I documented administering the scheduled 4:00 p.m. dose of Oxycodone 5 mg to R1 at 2:28 p.m., "Due to condition." On 2/13/17, RN-I documented administering Oxycodone 5 mg PRN at 10:32 a.m. R1's MAR indicated on 2/13/17, at 10:32 a.m. RN-I obtained a one time PRN order for Oxycodone 10 mg orally, give to resident per request prior to treatment. The order was entered by RN-I, and the Oxycodone 10 mg was documented as administered to R1 at 12:00 p.m. by RN-I. An undated facility investigation indicated on	F 431	other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. F431 483.45(b)(2)(3)(g)(h) Drug Records, Label/Store Drugs & Biologicals The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	

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CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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F 431	Continued From page 3 2/13/17, RN-I stated she called the on call triage physician and obtained a one time order for Oxycodone 10 mg orally for R1 to use prior to completing a treatment. RN-I stated she administered a dose of Oxycodone 5 mg to R1 at 2:28 p.m., and she had wasted a dose of Oxycodone 5 mg right after administering the 2:28 p.m. dose because she realized it was too soon to give R1 more pain medication. RN-I stated she wasted the Oxycodone by throwing the pill into the sharps container which was witnessed by TMA-C. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg (a diuretic). RN-I's electronic time tracking for hours worked indicated on 2/13/17, she clocked out of the facility at 2:38 p.m. The triage nurse and on call physicians were contacted and stated they had no record RN-I spoke with a physician or a nurse on 2/13/17, to obtain a one time order for Oxycodone 10 mg for R1. R1's medical record contained no documentation the resident was experiencing any increased or acute pain on 2/13/17. R1 was interviewed and stated he was not having any unusual or increased discomfort on 2/13/17, and denied requiring any additional doses of pain medication (Oxycodone). R2's physician orders indicated the resident had orders for Oxycodone 5 mg every 4 hours PRN for pain from 12/29/16, to 3/23/17. R2's narcotic record indicated on 2/13/17, RN-I documented removing Oxycodone 5 mg at 10:00 a.m. and at 1:00 p.m. The 10:00 a.m. entry was crossed out with a line drawn through it. There was no corresponding documentation regarding the 10:00 a.m. Oxycodone that RN-I removed.	F 431	(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals (1) 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. (2) 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	

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F 431	Continued From page 4 An undated facility investigation indicated on 2/13/17, RN-I stated she removed Oxycodone 5 mg at 10:00 a.m. but realized it was too soon to administer so she wasted it in the sharps container with TMA-C witnessing the destruction. RN-I stated she administered Oxycodone 5 mg to R2 at 1:00 p.m. on 2/13/17. R2 was interviewed and stated she did not request additional pain medication on 2/13/17, nor did she receive any. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg. R3's physician orders dated 3/28/17, indicated Oxycodone 5 mg oral every four hours PRN pain. R3's MAR for January 2017, indicated R3 received five doses of Oxycodone 5 mg, all five doses were administered by RN-I. R3's MAR for February 2017, was reviewed from 2/1/17 to 2/13/17, which indicated the resident received three doses of Oxycodone 5 mg, which were all administered by RN-I. A facility investigation dated 2/22/17, indicated R3 had a prescription of Oxycodone 5 mg PRN every four hours for back pain. From 12/20/16, to 2/13/17, all PRN doses of Oxycodone were administered by RN-I. R3's medical record contained only three progress notes to correspond with the administration of PRN Oxycodone written by RN-I which indicated R3 had generalized pain, arm pain, and/ or neck pain. R3's medical record contained no further documentation from any other staff indicating the resident had any signs or symptoms of pain. R10's physician orders indicated from 7/10/16, to 11/2/16, the resident had an order for Oxycodone 10 mg every hour PRN for pain or labored	F 431	subject to 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. Based on interview and document review, the facility failed to ensure every administration of a narcotic medication was documented on the medication administration record (MAR) to ensure accurate reconciliation of controlled medications and minimize potential drug diversion. Residents R1, R2, R3, R 10 and R11 had no negative outcome. Staff member RN-1 employment was terminated on 2/13/2017. Staff member TMA-C received re-education on policy/procedures of administering, handling, storage, disposal and documentation of Schedule II and other controlled substances and only documenting witnessed disposal of medication when observed the disposal of medication. An audit of documentation for those residents currently receiving Schedule II medications will be completed to assure accurate reconciliation will be completed by November 3, 2017. The facility has policies and procedures in place related to administering, handling, storage, disposal and documentation of	

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F 431	Continued From page 5 breathing. R10's MAR for October 2016, indicated R10 received 5 doses of PRN Oxycodone, all documented as administered by RN-I. R10's MAR indicated RN-I administered PRN Oxycodone 5 mg on 10/19/16, at 6:34 p.m. and 10:20 p.m. R10's Narcotic record indicated RN-I removed PRN Oxycodone 5 mg on 10/19/16, at 6:30 p.m., 9:00 p.m., and 10:00 p.m. There is no documentation on the MAR regarding the additional dose of Oxycodone removed. R10's nursing progress note dated 10/13/16, indicated the resident was receiving hospice services. The hospice nurse spoke with the facility staff and indicated R10 was currently not having any pain, however, the evening nurse on 10/12/16, RN-I, signed out in the narcotic book she administered three doses of PRN Oxycodone. R10's MAR had no documentation R10 was administered any of the three PRN Oxycodone signed out in the Narcotic record on 10/12/16. R11's physician orders indicated from 8/8/16, to 1/8/17, R11 had an order for Oxycodone 2.5 mg oral PRN every four hours for pain. R11's October 2016, MAR indicated the resident received six doses of Oxycodone, three were administered by RN-I on 10/5/16, 10/19/16, and 10/26/16. R11's Narcotic sign out indicated RN-I removed Oxycodone 2.5 mg on 10/5/16, at 4:30 p.m. and again at 8:30 p.m., on 10/12/16, at 8:00 p.m., 10/19/16, at 7:00 p.m., and 10/26/16, at 7:29 p.m. Although RN-I documented in the narcotic book removing Oxycodone 2.5 mg five times in October 2016, R11's MAR indicated	F 431	Schedule II and other controlled substances. Policies and Procedures were reviewed and revised to include: a) for loss or spillage an explanatory notation must be made in the Schedule II Record (Bound Narcotic Book) and notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction b) documentation of medication administration in resident s medical record after medication is received by residents. Education will be provided for all licensed nursing personnel and staff authorized to administer medications and handle controlled substances to ensure understanding of the current policies. Education will be completed by November 13, 2017 and new licensed nursing staff will receive education regarding the policies listed above during new employee orientation. Documentation and reconciliation audits which include – documentation of medication removal in Narcotic Log Book, documentation of administration in resident's "electronic medical record", documentation (explanatory note) of "wasted medication" in Narcotic Log Book, documentation of "wasted medication" has 2 witnesses and documentation signature of 2 witnesses and documentation of narcotic inventory review every shift is occurring per policy. These will occur on all residents receiving Schedule II medications weekly for one	

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F 431	Continued From page 6 Oxycodone was administered by RN-I only three times. A facility email from RN-I, to the DON and human resource representative (HRR)-J dated 7/5/16, indicated RN-I felt pain management was very personal to her and she needed to take a deeper look into how she assessed residents' pain and take her personal fear of seeing people in pain away. RN-I indicated she needed to make better "judgement calls," and look at resident past narcotic PRN usage prior to administering any PRN pain medication to the resident. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 11/11/16, indicated the DON met with RN-I to discuss her excessive PRN narcotic administration. RN-I was given a verbal warning due to multiple administration of narcotic medication without documentation to support the reason. The improvement performance plan indicated RN-I was to review the need for any resident PRN narcotic administration with another nurse prior to administration and to document findings in the resident medical record. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 12/15/16, indicated the DON met with RN-I and gave her a verbal warning for continued administration of PRN narcotics to residents when other licensed staff were not administering PRN's at the same frequency. The improvement plan indicated RN-I was to continue with current practice for review with another floor nurse for administration of PRN narcotic medication. When interviewed on 3/28/17, at 9:40 a.m. RN-G	F 431	month and monthly for one quarter and then as needed as determined by audit results and Quality Assurance. Any deviations from policy found in audits will be addressed and staff retraining will occur. Analysis of the audits and compliance will be presented to our Quality Assurance Committee who will who will determine when compliance is indicated. The Director of Nursing is responsible for this plan of correction. Completion date: November 13, 2017	

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F 431	Continued From page 7 stated she had concerns about excessive PRN administration by RN-I since approximately October 2016. RN-G stated after RN-I would work she noticed that narcotic medications, specifically Oxycodone and Tramadol, were documented as administered to residents, however, the residents would have no complaints of pain according to any other staff who were working. RN-G stated she spoke to the DON regarding the concerns with RN-I, and the DON told her the facility was looking into it and monitoring RN-I. RN-G stated she was not directed to monitor RN-I. When interviewed on 3/28/17, at 10:10 a.m. Licensed Practical Nurse (LPN)-H stated in October and November 2016, RN-I often requested to work in the memory care unit. LPN-H stated she noticed when RN-I was working she would sign out more PRN narcotics than other staff. LPN-H stated most of the residents had memory or cognitive issues and were unable to verify if they had increased pain and/ or if they had requested PRN narcotic medication. LPN-H stated at the beginning of December 2016, she reviewed all the residents in the memory care unit who had PRN pain medication available for use and completed a pain assessment. If the residents were not utilizing the PRN pain medication and were not having any signs or symptoms of pain the PRN pain medication was discontinued. LPN-H stated RN-I was supposed to be having a second nurse sign off and assess the patient prior to administration of any PRN narcotic, however, this was not being completed. When interviewed on 3/28/17, at 10:55 a.m. TMA-C stated RN-I had asked her several times	F 431		

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F 431	Continued From page 8 in the past to sign off in the narcotic book witnessing destruction of narcotic medication. TMA-C was unable to recall the resident, medication, date, or exact number of times she had signed for witnessing destruction of a narcotic with RN-I. TMA-C stated RN-I would ask her to sign the narcotic book and say that she had to destroy the narcotic, however, TMA-C never actually observed the destruction. TMA-C stated when a narcotic medication was being destroyed, the destruction should be witnessed by two staff. When interviewed on 3/28/17, at 12:30 p.m. the DON stated over a year ago the facility had concerns about a potential drug diversion when discovering a resident's liquid morphine appeared watered down. When the facility was doing audits they noted RN-I was documenting excessive PRN administration. RN-I was picking up most shifts in the memory care unit in November and December 2016, and was administering more PRN narcotic than other staff. The DON met with RN-I in July 2016, November 2016, and December 2016, to discuss concerns related to excessive PRN administration. The DON stated RN-I was still administering excessive amounts of PRN narcotics after the discussions, and was not having another staff assess the resident and sign off on the administration of the PRN narcotic as directed. The DON stated on 2/13/17, after discovering the narcotic record for R1 and R2, RN-I was asked about the inconsistency's in the resident's record. RN-I emailed the facility and told them she would no longer be working at the facility. When interviewed on 7/5/17, at 10:00 a.m. RN-I stated she felt the other staff at the facility did not	F 431		

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F 431	Continued From page 9 recognize resident's pain, and controlling resident's pain was a priority for her. RN-I stated although it appeared she was giving more PRN narcotic medication than other nurses, she was using her nursing judgement. RN-I stated when she destroyed the narcotic medication, TMA-C signed off she witnessed the destruction. RN-I stated she quit working at the facility because they were questioning her nursing judgement for managing resident's pain. The facility policy titled Controlled Substances dated 7/1/16, indicated the DON would investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties. The facility policy titled Controlled Substances Destruction dated 7/1/16, indicated the nurse would inform the clinic manager on the unit of a controlled substance that needed to be destroyed and two licensed staff members would ensure the narcotic book was updated with the disposal witnessed by two licensed staff members.	F 431		

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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: Surveyor: 29249 A complaint investigation was conducted to investigate complaint #H5365024, H5365025, and H5365026. As a result, the following correction orders are issued related to case #H5365024, H5365025, and H5365026. The facility has agreed to participate in the electronic	2 000		

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2 000	Continued From page 1 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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		
21635	MN Rule 4658.1350 Subp. 3 Disposition of Medications; Loss or spillage Subp. 3. Loss or spillage. When a loss or spillage of a prescribed Schedule II drug occurs, an explanatory notation must be made in a Schedule II record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill. This MN Requirement is not met as evidenced by: Surveyor: 29249 Based on interview and document review, the facility failed to ensure every administration of a narcotic medication was documented on the medication administration record (MAR) to ensure accurate reconciliation of controlled medications and minimize potential drug diversion for 5 of 11 residents reviewed, R1, R2,	21635	Corrected	11/13/17

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21635	Continued From page 2	21635		

R3, R10, and R11, who had a narcotic record indicated narcotic medication was removed, however, there was no corresponding documenting in the resident's medical record indicating they received the narcotic medication.

Findings include:

R1's physician orders dated 3/27/17, included Oxycodone 5 mg tablet three times a day for pain, and Oxycodone 5 mg tablet every 6 hours as needed (PRN) for pain.

R1's narcotic record indicated on 1/29/17, at 11:00 a.m. Registered Nurse (RN)-I removed Oxycodone 5 mg for R1. Written in the narcotic book next to RN-I signature was "wasted." Trained Medication Assistant (TMA)-C initialed next to RN-I's initials. There was no corresponding documentation why the Oxycodone was removed and not administered. R1's narcotic record indicated on 2/13/17, RN-I removed Oxycodone 5 mg at 10:20 a.m., 12:00 p.m., and 3:00 p.m. There was also another Oxycodone 5 mg removed dated 2/13/17, however, there was no time. Written next to the signature of RN-I and TMA-C was "wasted." R1's MAR indicated on 2/13/17, RN-I documented administering the scheduled 4:00 p.m. dose of Oxycodone 5 mg to R1 at 2:28 p.m., "Due to condition." On 2/13/17, RN-I documented administering Oxycodone 5 mg PRN at 10:32 a.m. R1's MAR indicated on 2/13/17, at 10:32 a.m. RN-I obtained a one time PRN order for Oxycodone 10 mg orally, give to resident per request prior to treatment. The order was entered by RN-I, and the Oxycodone 10 mg was documented as administered to R1 at 12:00 p.m. by RN-I.

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21635	Continued From page 3 An undated facility investigation indicated on 2/13/17, RN-I stated she called the on call triage physician and obtained a one time order for Oxycodone 10 mg orally for R1 to use prior to completing a treatment. RN-I stated she administered a dose of Oxycodone 5 mg to R1 at 2:28 p.m., and she had wasted a dose of Oxycodone 5 mg right after administering the 2:28 p.m. dose because she realized it was too soon to give R1 more pain medication. RN-I stated she wasted the Oxycodone by throwing the pill into the sharps container which was witnessed by TMA-C. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg (a diuretic). RN-I's electronic time tracking for hours worked indicated on 2/13/17, she clocked out of the facility at 2:38 p.m. The triage nurse and on call physicians were contacted and stated they had no record RN-I spoke with a physician or a nurse on 2/13/17, to obtain a one time order for Oxycodone 10 mg for R1. R1's medical record contained no documentation the resident was experiencing any increased or acute pain on 2/13/17. R1 was interviewed and stated he was not having any unusual or increased discomfort on 2/13/17, and denied requiring any additional doses of pain medication (Oxycodone). R2's physician orders indicated the resident had orders for Oxycodone 5 mg every 4 hours PRN for pain from 12/29/16, to 3/23/17. R2's narcotic record indicated on 2/13/17, RN-I documented removing Oxycodone 5 mg at 10:00 a.m. and at 1:00 p.m. The 10:00 a.m. entry was crossed out with a line drawn through it. There was no corresponding documentation regarding the 10:00 a.m. Oxycodone that RN-I removed.	21635		

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21635	Continued From page 4 An undated facility investigation indicated on 2/13/17, RN-I stated she removed Oxycodone 5 mg at 10:00 a.m. but realized it was too soon to administer so she wasted it in the sharps container with TMA-C witnessing the destruction. RN-I stated she administered Oxycodone 5 mg to R2 at 1:00 p.m. on 2/13/17. R2 was interviewed and stated she did not request additional pain medication on 2/13/17, nor did she receive any. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg. R3's physician orders dated 3/28/17, indicated Oxycodone 5 mg oral every four hours PRN pain. R3's MAR for January 2017, indicated R3 received five doses of Oxycodone 5 mg, all five doses were administered by RN-I. R3's MAR for February 2017, was reviewed from 2/1/17 to 2/13/17, which indicated the resident received three doses of Oxycodone 5 mg, which were all administered by RN-I. A facility investigation dated 2/22/17, indicated R3 had a prescription of Oxycodone 5 mg PRN every four hours for back pain. From 12/20/16, to 2/13/17, all PRN doses of Oxycodone were administered by RN-I. R3's medical record contained only three progress notes to correspond with the administration of PRN Oxycodone written by RN-I which indicated R3 had generalized pain, arm pain, and/ or neck pain. R3's medical record contained no further documentation from any other staff indicating the resident had any signs or symptoms of pain. R10's physician orders indicated from 7/10/16, to 11/2/16, the resident had an order for Oxycodone 10 mg every hour PRN for pain or labored breathing.	21635		

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21635	Continued From page 5 R10's MAR for October 2016, indicated R10 received 5 doses of PRN Oxycodone, all documented as administered by RN-I. R10's MAR indicated RN-I administered PRN Oxycodone 5 mg on 10/19/16, at 6:34 p.m. and 10:20 p.m. R10's Narcotic record indicated RN-I removed PRN Oxycodone 5 mg on 10/19/16, at 6:30 p.m., 9:00 p.m., and 10:00 p.m. There is no documentation on the MAR regarding the additional dose of Oxycodone removed. R10's nursing progress note dated 10/13/16, indicated the resident was receiving hospice services. The hospice nurse spoke with the facility staff and indicated R10 was currently not having any pain, however, the evening nurse on 10/12/16, RN-I, signed out in the narcotic book she administered three doses of PRN Oxycodone. R10's MAR had no documentation R10 was administered any of the three PRN Oxycodone signed out in the Narcotic record on 10/12/16. R11's physician orders indicated from 8/8/16, to 1/8/17, R11 had an order for Oxycodone 2.5 mg oral PRN every four hours for pain. R11's October 2016, MAR indicated the resident received six doses of Oxycodone, three were administered by RN-I on 10/5/16, 10/19/16, and 10/26/16. R11's Narcotic sign out indicated RN-I removed Oxycodone 2.5 mg on 10/5/16, at 4:30 p.m. and again at 8:30 p.m., on 10/12/16, at 8:00 p.m., 10/19/16, at 7:00 p.m., and 10/26/16, at 7:29 p.m. Although RN-I documented in the narcotic book removing Oxycodone 2.5 mg five times in October 2016, R11's MAR indicated Oxycodone was administered by RN-I only three times.	21635		

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21635	Continued From page 6 A facility email from RN-I, to the DON and human resource representative (HRR)-J dated 7/5/16, indicated RN-I felt pain management was very personal to her and she needed to take a deeper look into how she assessed residents' pain and take her personal fear of seeing people in pain away. RN-I indicated she needed to make better "judgement calls," and look at resident past narcotic PRN usage prior to administering any PRN pain medication to the resident. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 11/11/16, indicated the DON met with RN-I to discuss her excessive PRN narcotic administration. RN-I was given a verbal warning due to multiple administration of narcotic medication without documentation to support the reason. The improvement performance plan indicated RN-I was to review the need for any resident PRN narcotic administration with another nurse prior to administration and to document findings in the resident medical record. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 12/15/16, indicated the DON met with RN-I and gave her a verbal warning for continued administration of PRN narcotics to residents when other licensed staff were not administering PRN's at the same frequency. The improvement plan indicated RN-I was to continue with current practice for review with another floor nurse for administration of PRN narcotic medication. When interviewed on 3/28/17, at 9:40 a.m. RN-G stated she had concerns about excessive PRN administration by RN-I since approximately October 2016. RN-G stated after RN-I would	21635		

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21635	Continued From page 7 work she noticed that narcotic medications, specifically Oxycodone and Tramadol, were documented as administered to residents, however, the residents would have no complaints of pain according to any other staff who were working. RN-G stated she spoke to the DON regarding the concerns with RN-I, and the DON told her the facility was looking into it and monitoring RN-I. RN-G stated she was not directed to monitor RN-I. When interviewed on 3/28/17, at 10:10 a.m. Licensed Practical Nurse (LPN)-H stated in October and November 2016, RN-I often requested to work in the memory care unit. LPN-H stated she noticed when RN-I was working she would sign out more PRN narcotics than other staff. LPN-H stated most of the residents had memory or cognitive issues and were unable to verify if they had increased pain and/ or if they had requested PRN narcotic medication. LPN-H stated at the beginning of December 2016, she reviewed all the residents in the memory care unit who had PRN pain medication available for use and completed a pain assessment. If the residents were not utilizing the PRN pain medication and were not having any signs or symptoms of pain the PRN pain medication was discontinued. LPN-H stated RN-I was supposed to be having a second nurse sign off and assess the patient prior to administration of any PRN narcotic, however, this was not being completed. When interviewed on 3/28/17, at 10:55 a.m. TMA-C stated RN-I had asked her several times in the past to sign off in the narcotic book witnessing destruction of narcotic medication. TMA-C was unable to recall the resident, medication, date, or exact number of times she	21635		

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21635	Continued From page 8	21635		

had signed for witnessing destruction of a narcotic with RN-I. TMA-C stated RN-I would ask her to sign the narcotic book and say that she had to destroy the narcotic, however, TMA-C never actually observed the destruction. TMA-C stated when a narcotic medication was being destroyed, the destruction should be witnessed by two staff.

When interviewed on 3/28/17, at 12:30 p.m. the DON stated over a year ago the facility had concerns about a potential drug diversion when discovering a resident's liquid morphine appeared watered down. When the facility was doing audits they noted RN-I was documenting excessive PRN administration. RN-I was picking up most shifts in the memory care unit in November and December 2016, and was administering more PRN narcotic than other staff. The DON met with RN-I in July 2016, November 2016, and December 2016, to discuss concerns related to excessive PRN administration. The DON stated RN-I was still administering excessive amounts of PRN narcotics after the discussions, and was not having another staff assess the resident and sign off on the administration of the PRN narcotic as directed. The DON stated on 2/13/17, after discovering the narcotic record for R1 and R2, RN-I was asked about the inconsistency's in the resident's record. RN-I emailed the facility and told them she would no longer be working at the facility.

When interviewed on 7/5/17, at 10:00 a.m. RN-I stated she felt the other staff at the facility did not recognize resident's pain, and controlling resident's pain was a priority for her. RN-I stated although it appeared she was giving more PRN narcotic medication than other nurses, she was using her nursing judgement. RN-I stated when

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21635	Continued From page 9 she destroyed the narcotic medication, TMA-C signed off she witnessed the destruction. RN-I stated she quit working at the facility because they were questioning her nursing judgement for managing resident's pain. The facility policy titled Controlled Substances dated 7/1/16, indicated the DON would investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties. The facility policy titled Controlled Substances Destruction dated 7/1/16, indicated the nurse would inform the clinic manager on the unit of a controlled substance that needed to be destroyed and two licensed staff members would ensure the narcotic book was updated with the disposal witnessed by two licensed staff members. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could update the narcotic count policy to include reconciliation of records, and the medication pass policy to include documenting medication following administration. The DON could provide training to all the nursing staff. The DON could randomly audit narcotic medication counts and documentation records. The quality assessment and assurance committee could implement monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21635		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment.	21850		11/13/17

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21850	Continued From page 10 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 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: Surveyor: 29249 Based on interview and document review, the facility failed to ensure 5 of 11 residents reviewed, R1, R2, R3, R10, and R11, were free from maltreatment. The residents were financially exploited with their narcotic medication was stolen by a staff member. Findings include: R1's physician orders dated 3/27/17, included Oxycodone 5 mg tablet three times a day for pain, and Oxycodone 5 mg tablet every 6 hours as needed (PRN) for pain. R1's narcotic record indicated on 1/29/17, at 11:00 a.m. Registered Nurse (RN)-I removed Oxycodone 5 mg for R1. Written in the narcotic book next to RN-I signature was "wasted." Trained Medication Assistant (TMA)-C initialed next to RN-I's initials. There was no corresponding documentation why the	21850	Corrected	

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21850	Continued From page 11 Oxycodone was removed and not administered. R1's narcotic record indicated on 2/13/17, RN-I removed Oxycodone 5 mg at 10:20 a.m., 12:00 p.m., and 3:00 p.m. There was also another Oxycodone 5 mg removed dated 2/13/17, however, there was no time. Written next to the signature of RN-I and TMA-C was "wasted." R1's MAR indicated on 2/13/17, RN-I documented administering the scheduled 4:00 p.m. dose of Oxycodone 5 mg to R1 at 2:28 p.m., "Due to condition." On 2/13/17, RN-I documented administering Oxycodone 5 mg PRN at 10:32 a.m. R1's MAR indicated on 2/13/17, at 10:32 a.m. RN-I obtained a one time PRN order for Oxycodone 10 mg orally, give to resident per request prior to treatment. The order was entered by RN-I, and the Oxycodone 10 mg was documented as administered to R1 at 12:00 p.m. by RN-I. An undated facility investigation indicated on 2/13/17, RN-I stated she called the on call triage physician and obtained a one time order for Oxycodone 10 mg orally for R1 to use prior to completing a treatment. RN-I stated she administered a dose of Oxycodone 5 mg to R1 at 2:28 p.m., and she had wasted a dose of Oxycodone 5 mg right after administering the 2:28 p.m. dose because she realized it was too soon to give R1 more pain medication. RN-I stated she wasted the Oxycodone by throwing the pill into the sharps container which was witnessed by TMA-C. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg (a diuretic). RN-I's electronic time tracking for hours worked indicated on 2/13/17, she clocked out of the facility at 2:38 p.m. The triage nurse and on call physicians were contacted and stated they had no record RN-I spoke with a physician or a nurse on 2/13/17, to	21850		

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21850	Continued From page 12 obtain a one time order for Oxycodone 10 mg for R1. R1's medical record contained no documentation the resident was experiencing any increased or acute pain on 2/13/17. R1 was interviewed and stated he was not having any unusual or increased discomfort on 2/13/17, and denied requiring any additional doses of pain medication (Oxycodone). R2's physician orders indicated the resident had orders for Oxycodone 5 mg every 4 hours PRN for pain from 12/29/16, to 3/23/17. R2's narcotic record indicated on 2/13/17, RN-I documented removing Oxycodone 5 mg at 10:00 a.m. and at 1:00 p.m. The 10:00 a.m. entry was crossed out with a line drawn through it. There was no corresponding documentation regarding the 10:00 a.m. Oxycodone that RN-I removed. An undated facility investigation indicated on 2/13/17, RN-I stated she removed Oxycodone 5 mg at 10:00 a.m. but realized it was too soon to administer so she wasted it in the sharps container with TMA-C witnessing the destruction. RN-I stated she administered Oxycodone 5 mg to R2 at 1:00 p.m. on 2/13/17. R2 was interviewed and stated she did not request additional pain medication on 2/13/17, nor did she receive any. The facility removed the only pill in the sharps container which was identified as Lasix 20 mg. R3's physician orders dated 3/28/17, indicated Oxycodone 5 mg oral every four hours PRN pain. R3's MAR for January 2017, indicated R3 received five doses of Oxycodone 5 mg, all five doses were administered by RN-I. R3's MAR for February 2017, was reviewed from 2/1/17 to 2/13/17, which indicated the resident received	21850		

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21850	Continued From page 13 three doses of Oxycodone 5 mg, which were all administered by RN-I. A facility investigation dated 2/22/17, indicated R3 had a prescription of Oxycodone 5 mg PRN every four hours for back pain. From 12/20/16, to 2/13/17, all PRN doses of Oxycodone were administered by RN-I. R3's medical record contained only three progress notes to correspond with the administration of PRN Oxycodone written by RN-I which indicated R3 had generalized pain, arm pain, and/ or neck pain. R3's medical record contained no further documentation from any other staff indicating the resident had any signs or symptoms of pain. R10's physician orders indicated from 7/10/16, to 11/2/16, the resident had an order for Oxycodone 10 mg every hour PRN for pain or labored breathing. R10's MAR for October 2016, indicated R10 received 5 doses of PRN Oxycodone, all documented as administered by RN-I. R10's MAR indicated RN-I administered PRN Oxycodone 5 mg on 10/19/16, at 6:34 p.m. and 10:20 p.m. R10's Narcotic record indicated RN-I removed PRN Oxycodone 5 mg on 10/19/16, at 6:30 p.m., 9:00 p.m., and 10:00 p.m. There is no documentation on the MAR regarding the additional dose of Oxycodone removed. R10's nursing progress note dated 10/13/16, indicated the resident was receiving hospice services. The hospice nurse spoke with the facility staff and indicated R10 was currently not having any pain, however, the evening nurse on 10/12/16, RN-I, signed out in the narcotic book she administered three doses of PRN Oxycodone. R10's MAR had no documentation	21850		

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21850	Continued From page 14 R10 was administered any of the three PRN Oxycodone signed out in the Narcotic record on 10/12/16. R11's physician orders indicated from 8/8/16, to 1/8/17, R11 had an order for Oxycodone 2.5 mg oral PRN every four hours for pain. R11's October 2016, MAR indicated the resident received six doses of Oxycodone, three were administered by RN-I on 10/5/16, 10/19/16, and 10/26/16. R11's Narcotic sign out indicated RN-I removed Oxycodone 2.5 mg on 10/5/16, at 4:30 p.m. and again at 8:30 p.m., on 10/12/16, at 8:00 p.m., 10/19/16, at 7:00 p.m., and 10/26/16, at 7:29 p.m. Although RN-I documented in the narcotic book removing Oxycodone 2.5 mg five times in October 2016, R11's MAR indicated Oxycodone was administered by RN-I only three times. A facility email from RN-I, to the DON and human resource representative (HRR)-J dated 7/5/16, indicated RN-I felt pain management was very personal to her and she needed to take a deeper look into how she assessed residents' pain and take her personal fear of seeing people in pain away. RN-I indicated she needed to make better "judgement calls," and look at resident past narcotic PRN usage prior to administering any PRN pain medication to the resident. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 11/11/16, indicated the DON met with RN-I to discuss her excessive PRN narcotic administration. RN-I was given a verbal warning due to multiple administration of narcotic medication without documentation to support the reason. The improvement performance plan	21850		

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21850	Continued From page 15 indicated RN-I was to review the need for any resident PRN narcotic administration with another nurse prior to administration and to document findings in the resident medical record. A facility form titled Constructive Feedback/ Corrective Action, Performance Improvement Plan dated 12/15/16, indicated the DON met with RN-I and gave her a verbal warning for continued administration of PRN narcotics to residents when other licensed staff were not administering PRN's at the same frequency. The improvement plan indicated RN-I was to continue with current practice for review with another floor nurse for administration of PRN narcotic medication. When interviewed on 3/28/17, at 9:40 a.m. RN-G stated she had concerns about excessive PRN administration by RN-I since approximately October 2016. RN-G stated after RN-I would work she noticed that narcotic medications, specifically Oxycodone and Tramadol, were documented as administered to residents, however, the residents would have no complaints of pain according to any other staff who were working. RN-G stated she spoke to the DON regarding the concerns with RN-I, and the DON told her the facility was looking into it and monitoring RN-I. RN-G stated she was not directed to monitor RN-I. When interviewed on 3/28/17, at 10:10 a.m. Licensed Practical Nurse (LPN)-H stated in October and November 2016, RN-I often requested to work in the memory care unit. LPN-H stated she noticed when RN-I was working she would sign out more PRN narcotics than other staff. LPN-H stated most of the residents had memory or cognitive issues and were unable to verify if they had increased pain	21850		

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21850	Continued From page 16 and/ or if they had requested PRN narcotic medication. LPN-H stated at the beginning of December 2016, she reviewed all the residents in the memory care unit who had PRN pain medication available for use and completed a pain assessment. If the residents were not utilizing the PRN pain medication and were not having any signs or symptoms of pain the PRN pain medication was discontinued. LPN-H stated RN-I was supposed to be having a second nurse sign off and assess the patient prior to administration of any PRN narcotic, however, this was not being completed. When interviewed on 3/28/17, at 10:55 a.m. TMA-C stated RN-I had asked her several times in the past to sign off in the narcotic book witnessing destruction of narcotic medication. TMA-C was unable to recall the resident, medication, date, or exact number of times she had signed for witnessing destruction of a narcotic with RN-I. TMA-C stated RN-I would ask her to sign the narcotic book and say that she had to destroy the narcotic, however, TMA-C never actually observed the destruction. TMA-C stated when a narcotic medication was being destroyed, the destruction should be witnessed by two staff. When interviewed on 3/28/17, at 12:30 p.m. the DON stated over a year ago the facility had concerns about a potential drug diversion when discovering a resident's liquid morphine appeared watered down. When the facility was doing audits they noted RN-I was documenting excessive PRN administration. RN-I was picking up most shifts in the memory care unit in November and December 2016, and was administering more PRN narcotic than other staff. The DON met with RN-I in July 2016, November	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00354	A. BUILDING: _____ B. WING _____	C 10/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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21850	Continued From page 17 2016, and December 2016, to discuss concerns related to excessive PRN administration. The DON stated RN-I was still administering excessive amounts of PRN narcotics after the discussions, and was not having another staff assess the resident and sign off on the administration of the PRN narcotic as directed. The DON stated on 2/13/17, after discovering the narcotic record for R1 and R2, RN-I was asked about the inconsistency's in the resident's record. RN-I emailed the facility and told them she would no longer be working at the facility. When interviewed on 7/5/17, at 10:00 a.m. RN-I stated she felt the other staff at the facility did not recognize resident's pain, and controlling resident's pain was a priority for her. RN-I stated although it appeared she was giving more PRN narcotic medication than other nurses, she was using her nursing judgement. RN-I stated when she destroyed the narcotic medication, TMA-C signed off she witnessed the destruction. RN-I stated she quit working at the facility because they were questioning her nursing judgement for managing resident's pain. The facility policy titled Controlled Substances dated 7/1/16, indicated the DON would investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties. The facility policy titled Controlled Substances Destruction dated 7/1/16, indicated the nurse would inform the clinic manager on the unit of a controlled substance that needed to be destroyed and two licensed staff members would ensure the narcotic book was updated with the disposal witnessed by two licensed staff members.	21850		

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21850	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could update the narcotic count policy to include reconciliation of records, and the medication pass policy to include documenting medication following administration. The DON could provide training to all the nursing staff. The DON could randomly audit narcotic medication counts and documentation records. The quality assessment and assurance committee could implement monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		