Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Cerenity Senior Care Marian	HL20167004	June 8 & 14, 2016

Facility Address:	Time of Visit:	Date Concluded:
200 Earl Street	9:30 a.m. -4:30 p.m., 9:00 a.m. - 10:00 a.m.	January 3, 2017

Facility City:	Investigator's Name and Title:
Saint Paul	Darin Hatch, Special Investigator

State:	ZIP:	County:
Minnesota	55106	Ramsey

☒ **Home Care**

Allegation(s):

It is alleged that several clients (#1, #2, #3, #4, #5, #6, #7, #8 and #9) were financially exploited when the alleged perpetrator (AP) took the clients' narcotic medications for his/her own personal use.

☒ 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) took medications from nine clients for his/her own personal use.

All nine clients received services from the home care provider for medication administration according to their service agreement and care plans. Client #1 had a physician's order for tramadol hydrochloride 50 milligrams (mg) and a physician's order for oxycodone 5 mg. Client #2 had a physician's order for tramadol hydrochloride 50 mg. Client #3 had a physician's order for hydrocodone/APAP 5/325 mg. Client #4 had a physician's order for oxycodone/APAP 5/325 mg and a physician's order for hydrocodone/APAP 5/325 mg. Client #5 had a physician's order for hydrocodone/APAP 5/325 mg. Client #6 had a physician's order for hydrocodone/APAP 5/325 mg. Client #7 had a physician's order for hydrocodone/APAP 5/325 mg. Client #8 had a physician's order for tramadol hydrochloride 50 mg. Client #9 had a physician's order for tramadol hydrochloride 50 mg.

Observations conducted during the onsite visit revealed clients' controlled substance medications are centrally stored double locked in a medication cart in the nurses' station. Only licensed staff are allowed to administer the controlled substance medications and only licensed staff have a key to access the controlled substance medications. There was one set of keys belonging to licensed staff that were exchanged at shift change, and staff also double count the controlled substance medications at shift change. At the time of the incident, the home care provider's policy required one licensed staff to receive and sign for controlled substance medications that were delivered from the pharmacy. Since the incident, two licensed staff receive and sign for controlled substance medications that are delivered from the pharmacy. In addition, at the time of the incident, any two licensed staff could destroy and document medication destructions. Since

the incident, only two dedicated registered nurses destroy and document medication destructions.

A registered nurse received reports from two staff indicating that a quantity of tramadol hydrochloride were missing from the medication cart on the fourth floor. The nurse investigated and concluded one card of tramadol was missing. S/he also noted that the narcotic medication book appeared to contain places where his/her signature had been forged at places where two signatures were required for the destruction of medications. Each time his/her signature did not appeared authentic, the second signature was the AP. Review of the packing slips from the pharmacy also showed discrepancies between the amount delivered and the amount added to the inventory in the narcotic books; for all nine clients, there were instances where some of the medications signed for by the AP on the packing lists were not added to the inventory in the narcotic books. These discrepancies totaled around 1554 tablets over a period of three months, and involved tramadol, oxycodone, and hydrocodone with acetaminophen.

The AP was interviewed with police present and admitted to taking the missing medications from the clients. Police forwarded their findings to the county attorney for charging.

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 AP's personnel file showed the AP's acknowledgment of receiving the "Employee Handbook" which indicated any theft was unacceptable in the workplace and was grounds for involuntary termination. The AP's personnel file showed the AP received training in regards to the policies in place. The home care provider had policies in place to prevent financial exploitation which claimed the facility took all reasonable precautions to eliminate the theft or misuse of controlled substances; however, the facility failed to control the narcotic medications for all nine clients.

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.

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:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ Service Plan
- ☒ Other, specify:

Other pertinent medical records:

[x] Police Report

Additional facility records:

[x] Staff Time Sheets, Schedules, etc.

[x] Facility Internal Investigation Reports

[x] Personnel Records/Background Check, etc.

[x] Facility In-service Records

[x] Facility Policies and Procedures

Number of additional resident(s) reviewed: 0

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

Specify: No additional reviewed

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 self-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: 9

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 4

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:

☒ Use of Equipment

☒ Medication Pass

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Meals

☒ Facility Tour

☒ Other: Medication storage

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 - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Saint Paul Police Department

Ramsey County Attorney

Saint Paul City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20167	A. BUILDING: ______ B. WING ______	C 07/21/2016

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

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On June 8, 2016, a complaint investigation was initiated to investigate complaint #HL20167004. At the time of the survey, there were 112 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 325 SS=F	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to ensure that nine of nine clients (C1), (C2), (C3), (C4), (C5), (C6), (C7), (C8), and (C9) reviewed were free from maltreatment when they were financially exploited by licensed practical nurse (LPN)-N who took the client's narcotic medications for her own personal use. The violation is issued as a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1's record was reviewed. C1 received services from the home care provider for medication administration according to a service agreement and care plan dated August 20, 2015. C1 had physician's orders dated February 18, 2016; March 21, 2016; and April 4, 2016 for tramadol hydrochloride 50 milligrams (mg), one tablet twice daily as needed for pain and a physician's order dated February 19, 2016 for oxycodone 5 mg , one tablet every six hours as needed for pain. C2's record was reviewed. C2 received services from the home care provider for medication	0 325		

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0 325	Continued From page 2 administration according to a service agreement and care plan dated August 14, 2015. C2 had physician's orders dated February 23, 2016; March 18, 2016; and April 11, 2016 for tramadol hydrochloride 50 mg, one tablet to be taken three times daily as needed for pain. C3's record was reviewed. C3 received services from the home care provider for medication administration according to a service agreement and care plan dated March 10, 2016. C3 had a physician's order dated April 18, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain. C4's record was reviewed. C4 received services from the home care provider for medication administration according to a service agreement and care plan dated July 30, 2010. C4 had physician's orders dated February 8 and 13, 2016; March 28, 2016; and April 23, 2016 for oxycodone/APAP 5/325 mg, one tablet to be taken every six hours for pain as needed and physician's orders dated February 25, 2016 and March 24, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain. C5's record was reviewed. C5 received services from the home care provider for medication administration according to a service agreement and care plan dated June 3, 2015. C5 had a physician's order dated April 4, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every six hours as needed for pain. C6's record was reviewed. C6 received services from the home care provider for medication administration according to a service agreement and care plan dated July 30, 2014. C6 had a	0 325		

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0 325	Continued From page 3 physician's order dated March 8, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain. C7's record was reviewed. C7 received services from the home care provider for medication administration according to a service agreement and care plan dated December 10, 2015. C7 had a physician's order dated February 15, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every six hours as needed for pain. C8's record was reviewed. C8 received services from the home care provider for medication administration according to a service agreement and care plan dated April 22, 2016. C8 had physician's orders dated March 7 and 31 for tramadol hydrochloride 50 mg, one tablet twice daily as scheduled and one tablet taken up to four times daily as needed for pain. C9's record was reviewed. C9 received services from the home care provider for medication administration according to a service agreement and care plan dated June 24, 2015. C9 had a physician's order dated March 7, 2016 for tramadol hydrochloride 50 mg, one tablet to be taken two times daily as needed for pain. Interview with registered nurse (RN)-B on June 8, 2016 at 11:35 a.m. revealed two staff reported to her on April 26, 2016 at approximately 6:00 a.m. that two cards of tramadol hydrochloride were missing from the medication cart on the fourth floor. RN-B investigated and discovered one card was actually used up legitimately but the other card was in fact missing. She examined the narcotic medication book and noticed her signature was forged where two signatures were required for the destruction of medications on	0 325		

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0 325	Continued From page 4 page 45. She said she is left handed and the signature was missing her left handed slant. She noticed that each time her signature appeared to be forged, the second signature was LPN-N. She notified the housing director (HD)-D and contacted the pharmacy to request all the packing slips that LPN-N had signed for since February and all the packing slips for all controlled substance medications delivered since February. RN-B said she matched all the packing slips with the narcotic books on the 4th and 5th floor and discovered discrepancies between the amount delivered and the amount added to the inventory in the narcotic books for clients C1 through C9. Some of the medications on packing lists signed for by LPN-N were not added to the inventory in the narcotic books on the 4th and 5th floor. RN-B said only LPN-N had discrepancies between the packing slips and what was inventoried in the narcotic books for clients C1 through C9. RN-B continued to investigate, interview staff, and review records along with HD-D. RN-B said she discovered LPN-N always wanted to be the person who destroyed controlled substance medications but never wanted to destroy non-controlled substance medications. RN-B said LPN-N called the physician more than other LPN's to indicate medications for some of the nine clients did not work and requested a change from one opioid medication to another, which would generate excess controlled substance medications that needed to be destroyed. RN-B said LPN-N would often call the physician again soon after documenting medication destruction and request the physician create an new order for a medication type she just documented the destruction of. RN-B said her investigation revealed LPN-N was documenting the destruction	0 325		

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0 325	Continued From page 5	0 325		

of medications by herself without a second witness and forging RN-B's signature in violation of the facility policy.

RN-B said at the time of the incident only one licensed staff was required to receive and sign for controlled substance medications that were delivered from the pharmacy. Since the incident, the procedure has been changed to have two licensed staff receive and sign for controlled substance medications that are delivered from the pharmacy. In addition, at the time of the incident, any two licensed staff could destroy and document medication destructions. Since the incident, only two dedicated registered nurses destroy and document medication destructions. RN-B said the facility has increased oversight and controls of the controlled substance intake and destruction process as a result of this incident to prevent future diversion of controlled substance medications.

Interview with HD-D on June 8, 2016 at 2:37 p.m. revealed she was contacted by RN-B on April 27, 2016 and informed RN-B suspected a drug diversion because RN-B had discovered her signature had been forged on controlled substance destruction records. HD-D said RN-B told her LPN-N had forged her signature on several occasions. She contacted the common entry point and police and investigated the suspected diversion along with RN-B. HD-D said she discovered LPN-N ordered and received controlled substance medications more frequently than other nurses and LPN-N did not inventory the pills as required into the narcotic books.

HD-D said she and RN-B reviewed documents received from the pharmacy along with narcotic book inventories and narcotic destruction

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0 325	Continued From page 6	0 325		

records. During the interview HD-D detailed the following pills were received by LPN-N but not inventoried into the narcotic books and were missing. She said the medications were last handled by LPN-N (1554 tablets total):

C1: 2-18-16-tramadol hydrochloride 50 mg, 60 tablets, 2-19-16 oxycodone 5 mg, 90 tablets, 3-21-16-tramadol hydrochloride 50 mg, 90 tablets, 4-4-16-tramadol hydrochloride 50 mg, 60 tablets for 300 tablets total.

C2: 2-23-16-tramadol hydrochloride 50 mg, 45 tablets, 3-18-16-tramadol hydrochloride 50 mg, 45 tablets, 4-11-16-tramadol hydrochloride 50 mg, 45 tablets for 135 tablets total.

C3: 4-18-16-hydrocodone/APAP 5/325 mg, 120 tablets total.

C4: 2-8-16-oxycodone/APAP 5/325 mg, 90 tablets, 2-13-16-oxycodone 5 mg, 120 tablets, 2-25-16-hydrocodone/APAP 5/325 mg, 90 tablets, 3-24-16-hydrocodone/APAP 5/325 mg, 84 tablets, 3-28-16-oxycodone/APAP 5/325 mg, 120 tablets, 4-23-16-oxycodone/APAP 5/325 mg, 120 tablets for 624 tablets total.

C5: 4-4-16-hydrocodone/APAP 5/325 mg, 90 tablets total.

C6: 3-8-16-hydrocodone/APAP 5/325 mg, 120 tablets total.

C7: 2-25-16-hydrocodone/APAP 5/325 mg, 120 tablets total.

C8: 3-7-16-tramadol hydrochloride 50 mg, 15 tablets, 3-31-16-tramadol hydrochloride 50 mg, 45 tablets for 60 tablets total.

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0 325	Continued From page 7	0 325		

C9: 3-7-16-tramadol hydrochloride 50 mg, 15 tablets total.

HD-D said during interview she discovered LPN-N wanted to be the person who destroyed controlled substance medications but never wanted to destroy non-controlled substance medications. HD-D said LPN-N frequently called the physician and requested a change from one opioid medication to another, which would generate excess waste of controlled substance medications that needed to be destroyed. HD-D said LPN-N would often call the physician again soon after documenting medication destruction and request the physician create an new order for a medication she just documented the destruction of. HD-D said LPN-N would frequently reorder medications for clients when there was no need for reordering as the client had plenty of supply left. HD-D said LPN-N was documenting the destruction of medications by herself without a second witness and forging RN-B's signature in violation of the facility policy.

Interview with LPN-N on July 19, 2016 at 12:22 p.m. revealed LPN-N admitted to taking the medication as detailed for C1, C2, C3, C4, C5, C6, C7, C8, and C9.

A police report dated May 2, 2016 and interview with police revealed they were notified by the facility of a suspected drug diversion. Police conducted an investigation and were present during the interview with LPN-N when LPN-N admitted to taking the medications from clients. Police forwarded their findings to the county attorney for charging.

A review of client files during the onsite

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0 325	Continued From page 8 investigation revealed signed copies of the home care bill of rights provided to C1, C2, C3, C4, C5, C6, C7, C8, and C9 by the home care provider that stated clients have the right to be free from maltreatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 900 SS=F	144A.4792, Subd. 1 Medication Management; Comprehensive Subdivision 1. Medication management services; comprehensive home care license. (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license. (b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for	0 900		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20167	A. BUILDING: ______ B. WING ______	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CC MARIAN ST PAUL	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) COMPLETE DATE
0 900	Continued From page 9 medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement a system for the control of narcotic medications for nine of nine clients (C1), (C2), (C3), (C4), (C5), (C6), (C7), (C8), and (C9) reviewed. This practice resulted in a level 2 violation (a violation that did not harm the client's health or safety but had the potential to have harmed a client's health or safety) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.) The findings included:	0 900		

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0 900	Continued From page 10 Observations conducted during the onsite visit revealed client controlled substance medications were centrally stored double locked in a medication cart in the nurses station. Only licensed staff are allowed to administer the controlled substance medications and only licensed staff have a key to access the controlled substance medications. There was one set of keys belonging to licensed staff that are exchanged at shift change and staff also double count the controlled substance medications at shift change. At the time of the incident only one licensed staff received and signed for controlled substance medications that were delivered from the pharmacy. Since the incident two licensed staff receive and sign for controlled substance medications that are delivered from the pharmacy. In addition, at the time of the incident, any two licensed staff could destroy and document medication destructions. Since the incident, only two dedicated registered nurses destroy and document medication destructions. C1's record was reviewed. C1 received services from the home care provider for medication administration according to a service agreement and care plan dated August 20, 2015. C1 had physician's orders dated February 18, 2016; March 21, 2016; and April 4, 2016 for tramadol hydrochloride 50 milligrams (mg), one tablet twice daily as needed for pain and a physician's order dated February 19, 2016 for oxycodone 5 mg, one tablet every six hours as needed for pain. C2's record was reviewed. C2 received services from the home care provider for medication administration according to a service agreement and care plan dated August 14, 2015. C2 had physician's orders dated February 23, 2016; March 18, 2016; and April 11, 2016 for tramadol	0 900		

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0 900	Continued From page 11 hydrochloride 50 mg, one tablet to be taken three times daily as needed for pain. C3's record was reviewed. C3 received services from the home care provider for medication administration according to a service agreement and care plan dated March 10, 2016. C3 had a physician's order dated April 18, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain. C4's record was reviewed. C4 received services from the home care provider for medication administration according to a service agreement and care plan dated July 30, 2010. C4 had physician's orders dated February 8 and 13, 2016; March 28, 2016; and April 23, 2016 for oxycodone/APAP 5/325 mg, one tablet to be taken every six hours for pain as needed and physician's orders dated February 25, 2016 and March 24, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain. C5's record was reviewed. C5 received services from the home care provider for medication administration according to a service agreement and care plan dated June 3, 2015. C5 had a physician's order dated April 4, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every six hours as needed for pain. C6's record was reviewed. C6 received services from the home care provider for medication administration according to a service agreement and care plan dated July 30, 2014. C6 had a physician's order dated March 8, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every four hours as needed for pain.	0 900		

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0 900	Continued From page 12 C7's record was reviewed. C7 received services from the home care provider for medication administration according to a service agreement and care plan dated December 10, 2015. C7 had a physician's order dated February 15, 2016 for hydrocodone/APAP 5/325 mg, one tablet to be taken every six hours as needed for pain. C8's record was reviewed. C8 received services from the home care provider for medication administration according to a service agreement and care plan dated April 22, 2016. C8 had physician's orders dated March 7 and 31 for tramadol hydrochloride 50 mg, one tablet twice daily as scheduled and one tablet taken up to four times daily as needed for pain. C9's record was reviewed. C9 received services from the home care provider for medication administration according to a service agreement and care plan dated June 24, 2015. C9 had a physician's order dated March 7, 2016 for tramadol hydrochloride 50 mg, one tablet to be taken two times daily as needed for pain. Interview with registered nurse (RN)-B on June 8, 2016 at 11:35 a.m. revealed two staff reported to her on April 26, 2016 at approximately 6:00 a.m. that two cards of tramadol hydrochloride were missing from the medication cart on the fourth floor. RN-B investigated and discovered one card was actually used up legitimately but the other card was in fact missing. She examined the narcotic medication book and noticed her signature was forged where two signatures were required for the destruction of medications on page 45. She said she is left handed and the signature was missing her left handed slant. She noticed that each time her signature appeared to be forged, the second signature was LPN-N. She	0 900		

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0 900	Continued From page 13 notified the housing director (HD)-D and contacted the pharmacy to request all the packing slips that LPN-N had signed for since February and all the packing slips for all controlled substance medications delivered since February. RN-B said she matched all the packing slips with the narcotic books on the 4th and 5th floor and discovered discrepancies between the amount delivered and the amount added to the inventory in the narcotic books for clients C1 through C9. Some of the medications on packing lists signed for by LPN-N were not added to the inventory in the narcotic books on the 4th and 5th floor. RN-B said only LPN-N had discrepancies between the packing slips and what was inventoried in the narcotic books for clients C1 through C9. RN-B continued to investigate, interview staff, and review records along with HD-D. RN-B said she discovered LPN-N always wanted to be the person who destroyed controlled substance medications but never wanted to destroy non-controlled substance medications. RN-B said LPN-N frequently called the physician more than other LPN's to indicate medications for some of the nine clients did not work and requested a change from one opioid medication to another, which would generate excess waste controlled substance medications that needed to be destroyed. RN-B said LPN-N would often call the physician again soon after documenting medication destruction and request the physician create an new order for a medication type she just documented the destruction of. RN-B said her investigation revealed LPN-N was documenting the destruction of medications by herself without a second witness and forging RN-B's signature in violation of the facility policy.	0 900		

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0 900	Continued From page 14 RN-B said at the time of the incident only one licensed staff was required to receive and sign for controlled substance medications that were delivered from the pharmacy. Since the incident, the procedure has been changed to require two licensed staff receive and sign for controlled substance medications that are delivered from the pharmacy. In addition, at the time of the incident, any two licensed staff could destroy and document medication destructions. Since the incident, only two dedicated registered nurses destroy and document medication destructions. RN-B said the facility has increased oversight and controls of the controlled substance intake and destruction process as a result of this incident to prevent future diversion of controlled substance medications. Interview with HD-D on June 8, 2016 at 2:37 p.m. revealed she was contacted by RN-B on April 27, 2016 and informed RN-B suspected a drug diversion because RN-B had discovered her signature had been forged on controlled substance destruction records. HD-D said RN-B told her LPN-N had forged RN-B's signature on several occasions. She contacted the common entry point and police and investigated the suspected diversion along with RN-B. HD-D said she discovered LPN-N ordered and received controlled substance medications more frequently than other nurses and LPN-N did not inventory the pills as required into the narcotic books. HD-D said she and RN-B reviewed documents received from the pharmacy along with narcotic book inventories and narcotic destruction records. During the interview HD-D detailed the following pills were received by LPN-N but not inventoried into the narcotic books and were missing. She said the medications were last	0 900		

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0 900	Continued From page 15 handled by LPN-N (1554 tablets total): C1: 2-18-16-tramadol hydrochloride 50 mg, 60 tablets, 2-19-16 oxycodone 5 mg, 90 tablets, 3-21-16-tramadol hydrochloride 50 mg, 90 tablets, 4-4-16-tramadol hydrochloride 50 mg, 60 tablets for 300 tablets total. C2: 2-23-16-tramadol hydrochloride 50 mg, 45 tablets, 3-18-16-tramadol hydrochloride 50 mg, 45 tablets, 4-11-16-tramadol hydrochloride 50 mg, 45 tablets for 135 tablets total. C3: 4-18-16-hydrocodone/APAP 5/325 mg, 120 tablets total. C4: 2-8-16-oxycodone/APAP 5/325 mg, 90 tablets, 2-13-16-oxycodone 5 mg, 120 tablets, 2-25-16-hydrocodone/APAP 5/325 mg, 90 tablets, 3-24-16-hydrocodone/APAP 5/325 mg, 84 tablets, 3-28-16-oxycodone/APAP 5/325 mg, 120 tablets, 4-23-16-oxycodone/APAP 5/325 mg, 120 tablets for 624 tablets total. C5: 4-4-16-hydrocodone/APAP 5/325 mg, 90 tablets total. C6: 3-8-16-hydrocodone/APAP 5/325 mg, 120 tablets total. C7: 2-25-16-hydrocodone/APAP 5/325 mg, 120 tablets total. C8: 3-7-16-tramadol hydrochloride 50 mg, 15 tablets, 3-31-16-tramadol hydrochloride 50 mg, 45 tablets for 60 tablets total. C9: 3-7-16-tramadol hydrochloride 50 mg, 15 tablets total.	0 900		

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0 900	Continued From page 16 HD-D said during interview she discovered LPN-N wanted to be the person who destroyed controlled substance medications but never wanted to destroy non-controlled substance medications. HD-D said LPN-N frequently called the physician and requested a change from one opioid medication to another, which would generate excess waste of controlled substance medications that needed to be destroyed. HD-D said LPN-N would often call the physician again soon after documenting medication destruction and request the physician create an new order for a medication she just documented the destruction of. HD-D said LPN-N would frequently reorder medications for clients when there was no need for reordering as the client had plenty of supply left. HD-D said LPN-N was documenting the destruction of medications by herself without a second witness and forging RN-B's signature in violation of the facility policy. HD-D said at the time of the incident only one licensed staff was required to receive and sign for controlled substance medications that were delivered from the pharmacy. Since the incident, two licensed staff receive and sign for controlled substance medications that are delivered from the pharmacy. In addition, at the time of the incident, any two licensed staff could destroy and document medication destructions. Since the incident, only two dedicated registered nurses destroy and document medication destructions. HD-D said the facility has increased oversight and controls of the controlled substance intake and destruction process as a result of this incident to prevent future diversion of controlled substance medications. A policy titled "Controlled Substances in Home Care" dated 2014-2015 revealed on page one	0 900		

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0 900	Continued From page 17 "this agency will take all reasonable precautions to eliminate the theft or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
H20167 Y1	A. Building B. Wing Y2	12/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CC MARIAN ST PAUL	200 EARL STREET SAINT PAUL, MN 55106

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 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 12/08/2016	ID Prefix 00900 Reg. # 144A.4792, Subd. 1 LSC	Correction Completed 12/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 7/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			