DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Minnesota Heritage House

Facility Address:
315 12th Street Northeast Suite B

Facility City:
Little Falls

State:	ZIP:	County:
Minnesota	56345	Morrison

Report Number:
HL21049037

Time of Visit:
10:30 a.m. to 5:00 p.m.
8:00 a.m. to 4:30 p.m.

Investigator's Name and Title:
Rhylee Gilb, RN, Special Investigator

Date of Visit:
August 31 and September 1, 2017

Date Concluded:
September 22, 2017

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when the care plan was not being followed when the client had a fall that resulted in death.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect did occur. Although the client fell, it was an isolated incident and s/he received treatment from the home care provider. However, there was a significant medication omission by the home care provider and the home care provider failed to follow up with the client's physician.

The client received services from the licensed, comprehensive home care provider. The client had a history of blood clots and stroke. The client received services from the home care provider which included assistance with dressing/grooming, bathing, incontinence care, transfers and medication administration. The client received a diuretic medication twice a day for swelling and subsequently received a potassium supplement three times a day to maintain his/her potassium level. A week prior to admission, the client's potassium blood level was at the low end of normal at 3.6 millmoles per liter (mmol/L). The client required assist of one person for transfers.

The Mayo Clinic indicates normal potassium level is between 3.6 and 5.2 (mmol/L). Potassium is critical to the proper function of nerve and muscles cells, particularly heart muscle cells.

Thirteen days after admission, the home care provider failed to provide the client 35 doses of potassium over 11 days, because a supply had not arrived from the pharmacy. The client utilized a pharmacy that mailed medications and required a seven to ten day processing time for medication refills.

There was no documentation that staff contacted a physician, checked the client's potassium level, or completed a medication error form after the 35 missed doses of potassium. Because the medication error form was not completed, facility policy was not followed and a nurse did not follow-up.

Approximately three weeks later while staff was assisting the client to get dressed, the client lost his/her balance and fell backwards. The staff member was not using a transfer belt. The next day, the client had back pain and went to urgent care. No fractures appeared on an x-ray and the client returned to the home care provider with pain medication. The client died three days later.

The death record indicated cause of death was vascular disease.

During an interview, the staff member said s/he knew the client's pharmacy took about ten days to send medications after ordering. S/he could not recall when s/he ordered the medication, but stated s/he ordered the medication. When it had not arrived, the staff member informed the nurse, who also ordered the medication.

During an interview, the nurse said s/he called the pharmacy and found out the medication had been shipped. The medication arrived in just a couple of days. The nurse said s/he did not know if the client's physician was updated after the missing doses.

During an interview, an administrative nurse said s/he spoke to the client's guardian about the medication. The administrative nurse offered to order the potassium at a local pharmacy which the guardian could purchase. In addition, the administrative nurse said she suggested that the guardian could ask the client's clinic to provide the medication. The administrative nurse said the guardian declined. The administrative nurse said the facility had no choice but to wait for the medication to arrive. The administrative nurse stated the client's physician was updated, but there was no longer any record of the fax communication.

During an interview, the client's guardian stated s/he was unaware the client had missed any doses of potassium, and the client was unable to keep track of his/her medications or update the guardian with medication discrepancies. The guardian stated s/he was never contacted by staff when the client's potassium supply was out. The guardian provided over-the-counter medications and staff contacted her/ him when those supplies were needed.

During an interview, the client's physician stated s/he could not recall if s/he was contacted by the home care provider regarding the client missing 35 doses of potassium. If s/he was, s/he would have ordered a potassium blood level drawn and no laboratory work was completed on the client during his/her stay at the home care provider. The physician stated the client had a history of medication non compliance and alcohol dependency which affected medication absorption. In relation to the potassium level and the fall, the physician said the impact of the missed doses on is unclear.

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 facility failed to ensure the client took prescribed medication and failed to provide evidence of contacting the client's physician about the missed doses. The facility did not complete a medication error form required by policy and did not follow-up.

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 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 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 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;

(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

(iii) the error is not part of a pattern of errors by the individual;

(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;

(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

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] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan

Other pertinent medical records:

- [x] Death Certificate
- [x] Other, specify:

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: four

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

Specify: multiple cases, one other medication error

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

○ Yes ○ No ◉ N/A

Specify: client is deceased

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:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews:attempted, dementia unit

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: five

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:

☒ Medication Pass

☒ Cleanliness

☒ Dignity/Privacy Issues

☒ Safety Issues

☒ Facility Tour

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

The Office of Ombudsman for Long-Term Care

Crow Wing

Pequot Lakes Police Department

Pequot Lakes City Attorney

Crow Wing County Attorney
Crow Wing County Medical Examiner

November 28, 2017

Administrator
Minnesota Heritage House
920 Southeast Fourth Street
Little Falls, MN 56345

RE: Complaint Number HL21049037, HL21049038, HL21049039, HL21049040, and HL21049041

Dear Adminstrator:

On November 17, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on September 25, 2017 with orders received by you on October 12, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please feel free to call me with any questions.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Crow Wing County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21049	A. BUILDING: _____ B. WING _____	R-C 11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

(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
{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL21049037, HL21049038, HL21049039, HL21049040 and HL21049041. Minnesota Heritage House was found in compliance with state regulations.	{0 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 1660 0000 4149 8044

October 3, 2017

Mr. James Birchem, Administrator
Minnesota Heritage House
920 Southeast Fourth Street
Little Falls, MN 56345

RE: Complaint Numbers HL21049037, HL21049038, HL21049039, HL21049040 and HL21049041

Dear Mr. Birchem:

A complaint investigation (#HL21049037, HL21049038, HL21049039, HL21049040 and HL21049041) of the Home Care Provider named above was completed on September 25, 2017, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Ms. Michelle Ness, Assistant Director
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

John Aglieco
Health Program Representative-Senior
Minnesota Department of Health
85 East Seventh Place, Suite 220
PO Box 64970
St Paul, MN 55164-0970
Office 651-201-4212 Fax: 651-281-9796

ja
Enclosure

cc: Home Health Care Assisted Living File
Morrison County Adult Protection
Office of Ombudsman
MN Department of Human Services

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	H21049	A. BUILDING: _____ B. WING _____	C 09/25/2017

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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, this correction order(s) has been 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 August 31, 2017 & September 1, 2017, a complaint investigation was initiated to investigate complaint #HL21049037, HL21049038, HL21049039, HL21049040 and HL21049041 at one licensee site. At the time of the survey, there were 48 clients receiving services under the comprehensive license. On August 31, 2017 and September 1, 2017, a complaint investigation was initiated to investigate complaint #HL21049039 at a second licensee site. At the time of the survey, there were 20 clients receiving services under the comprehensive license. The following correction orders are issued: 144A.4792 Subd. 1 is issued related to HL21049037, HL21049039 and HL21049041 144A.4792 Subd. 2 is issued related to HL21049039 144A.4792 Subd. 8 is issued related to HL21049037 and HL21049041	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 for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	

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0 000	Continued From page 1 144A.4792. Subd. 22 is issued related to HL21049039 144A.4794 Subd. 5 is issued related to HL21049037	0 000		
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (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 interview and document review, the licensee failed to follow up with the client's physician after a significant medication omission for one of five clients (C1) reviewed. The client died three weeks later. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1's service plan dated June 10, 2017 indicated C1 required assistance with dressing/grooming, bathing, incontinence care and medication administration. C1 had a history of blood clots and a stroke.	0 325		

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0 325	Continued From page 2 C1's clinic records were reviewed. C1 had a history of hypokalemia (low potassium level) and used diuretics (water pill) for chronic swelling. On May 30, 2017, C1's potassium blood level was at the low end of normal at 3.6 millmoles per liter (mmol/L). The Mayo Clinic indicates normal potassium level is between 3.6 and 5.2 (mmol/L). Potassium is critical to the proper function of nerve and muscles cells, particularly heart muscle cells. C1's Medication Administration Record dated June 2017, indicated C1 had a medication order for Torsemide (diuretic) 20 milligrams twice a day and Potassium 20 miliequivalents three times a day. C1's potassium was omitted June 19, 2017 through June 30, 2017, a total of 35 doses. The reason for omission was pharmacy had not delivered. C1 continued to receive Torsemide as directed. C1's clinic records indicated the potassium supply was last filled on June 28, 2017. Licensee pharmacy refill forms indicated on June 26, 2017 C1's potassium written on the form for refill. C1's record lacked documentation C1's physician was updated after missing 35 doses of potassium. C1's record also lacked record of any laboratory work completed while receiving services at the licensee. C1's progress notes were reviewed. On July 24, 2017, C1 experienced a fall while standing with ULP-E. C1 fell onto his bottom. July 25, 2017, C1 stated he had lower back pain and was sent to	0 325		

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0 325	Continued From page 3 urgent care. C1 had negative back X-rays and returned to the licensee with as needed pain medication. On July 28.2017, C1 died at the licensee while toileting. C1's death record indicated cause of death was vascular disease. On September 1, 2017 at 11:30 a.m., unlicensed personnel (ULP)-C stated C1's medications came from the Veteran's pharmacy and mediations take at least ten days to arrive after ordering. ULP-C ordered the potassium a couple of times and then licensed practical nurse (LPN)-B did too. During an interview on September 1, 2017, at 2:35 p.m. director of nursing (DON)-A stated C1's medications had not arrived from the pharmacy yet. C1's medications arrived by mail and took a while to process once ordered. The licensee tried to get the medication filled through a local pharmacy, but C1's guardian would had to pay for it or the guardian could pick it up from the clinic. DON-A stated the guardian was not willing to do either, therefore was the facility had no choice but to wait for the medication to arrive. On September 13, 2017 at 9:30 a.m., C1's guardian stated s/he was unaware C1 had missed any doses of potassium and C1 was unable to keep track of his/her medications. She was never contacted by the licensee when the C1's potassium supply was out, only when over-the-counter medications were low as she provided those. During an interview on September 13, 2017 at 2:10 p.m. LPN-B stated she did not complete C1's admission and was unaware what supply of medications C1 admitted with. Later one of the	0 325		

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0 325	Continued From page 4 ULP staff reported he was out of potassium and attempted to order through the wrong pharmacy. LPN-B called the Veteran's pharmacy and the pharmacy stated it had just been sent out. The medication arrived fairly quickly after the phone call. LPN-B stated medication error forms are not filled out when an omission was due to waiting for delivery from the pharmacy. On September 13, 2017 at 4:00 p.m., C1's physician stated she could not recall if she was contacted by the licensee regarding the client missing 35 doses of potassium. The physician stated if she was, she would have ordered a potassium blood level drawn and no laboratory work was completed on the client during his stay at the licensee. C1 had a history of medication non compliance and alcohol dependency which affected medication absorption. Therefore, the physician stated it is unclear how his potassium level would have been affected by missing 35 potassium doses and whether or not that contributed to the client's fall and/or death. The licensee policy titled "General Policies in Administering Medications" dated October 21, 2007, indicated a medication error includes medication omissions, a medication error report will be filled out and reported to the nurse. A policy related to pharmacy refill requests/medication ordering was requested, one was not provided. TIME PERIOD OF CORRECTION: 21 days	0 325		
0 900 SS=D	144A.4792, Subd. 1 Medication Management; Comprehensive	0 900		

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0 900	Continued From page 5 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 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	0 900		

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MINNESOTA HERITAGE HOUSE	920 SOUTHEAST FOURTH STREET LITTLE FALLS, MN 56345

(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 6 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 document review, observations, and interview, the licensee failed to order medications timely and medication omissions occurred as a result of no supply for two of five clients (C1, C5) reviewed. In addition, the licensee failed to provide timely reconciliation and destruction of a narcotic medication in order to prevent drug diversion for one of two clients (C6) discharged records reviewed. This practice resulted in a level two 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 was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: C1's medical record was reviewed. C1's service plan dated June 10, 2017 indicated C1 required assistance with dressing/grooming, bathing, incontinence care and medication administration.	0 900		

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0 900	Continued From page 7 C1's Medication Administration Record dated June 2017, indicated C1 had a medication order for Potassium 20 miliequivalents three times a day. C1's potassium was omitted June 19, 2017 through June 30, 2017, a total of 35 doses. The reason for omission was pharmacy had not delivered. C1's record lacked documentation C1's physician was updated after missing 35 doses of potassium. C1's record also lacked record of any laboratory work completed while receiving services at the licensee. On September 1, 2017 at 11:30 a.m., unlicensed personnel (ULP)-C stated C1's medications came from the Veteran's pharmacy, and mediations take at least ten days to arrive after ordering. ULP-C ordered the potassium a couple of time and then licensed practical nurse (LPN)-B did too. During an interview on September 1, 2017, at 2:35 p.m. director of nursing (DON)-A stated C1's medications had not arrived from the pharmacy yet. C1's medications arrived by mail and took a while to process once ordered. The licensee tried to get the medication filled through a local pharmacy, but C1's guardian would had to pay for it. The option was provided to C1's guardian or the guardian could have also drove the clinic to pick up the medication. On September 13, 2017 at 2:10 p.m. LPN-B stated she did not complete C1's admission and was unaware what supply of medications C1 admitted with. Later one of the ULP staff reported he was out of potassium. LPN-B called the Veteran's pharmacy and the pharmacy stated it had just been sent out. The medication arrived	0 900		

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0 900	Continued From page 8 fairly quickly after the phone call. C5's medical record was reviewed. C5's services plan dated August 14, 2017 indicated C5 required total assistance with all activities of daily living, assist of two staff and a total mechanical lift for transfers and medication administration. C5 had a history of psychiatric behaviors including an inpatient hospitalization in a psychiatric unit. A physician progress note dated August 19, 2017, dictated C5 began a decline in health status as indicated by increased weakness and decreased verbalization. Guardian and licensee were coordinating a hospice intake. C5's physician orders were reviewed. December 15, 2016 C5's scheduled Clonazepam was increased from 0.5 milligrams (mg) to 1 mg daily at bedtime. C5's medication administration record (MAR) was reviewed. Clonazepam was omitted due to no medication supply for the following dates: June 10, 2017 through June 14, 2017 June 30, 2017 through July 17, 2017 July 19, 2017 August 4, 2017 and August 5, 2017 C5's progress note dated August 5, 2017, dictated licensed practical nurse (LPN)-B contacted hospice and the pharmacy regarding no medication supply. During an interview on September 13, 2017 at 2:15 p.m., LPN-B stated she heard about the missing Clonazepam during morning report and called the pharmacy immediately. The pharmacy required a new prescription from C5's physician.	0 900		

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0 900	Continued From page 9 She messaged C5's physician electronically and requested a new script. A few days later, the Clonazepam still had not arrived and she called both the pharmacy and hospice. LPN-B stated shortly after that phone call the medication was delivered. LPN-B stated when the pharmacy cannot refill a medication for any reason, such needing a new prescription, the pharmacy sends a bright colored sheet to notify the facility in the evening medication delivery. LPN-B stated the home health aide staff are supposed to leave those slips for the nurses, but the nurses do not always receive the slips from the aides right away. A policy related to pharmacy refill requests/medication ordering was requested, one was not provided. C6's medical record was reviewed. C6's home health aide assignment sheet dated November 20, 2017, revealed C6 received comprehensive home care services from the licensee including medication management. Review of the licensee's Medication and Treatment Orders form established on February 28, 2017, the licensee received a physician's order for C6 to receive Roxanol liquid, a morphine or narcotic medication. The order directed staff to dispense five to ten milligrams (mg) or 0.25 to 0.5 cubic centimeter (cc) every two hours as needed for pain, shortness of breath or restlessness. In addition, on March 4, 2017, there was an order for C6 to receive hospice care. Review of the licensee's Individual Narcotic Record form dated March 1, 2017, revealed the licensee received the Roxanol 20 mg/milliliter (ml) in a 30 ml vial. C6 received a total of 11 doses	0 900		

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0 900	Continued From page 10 from March 3, 2017, until March 5, 2017, at 7:30 a.m. The documentation revealed following the last dose of Roxanol, there was 25.5 ml of Roxanol remaining in the vial. Review of the Hospice Medical Practitioner's Orders from dated March 4, 2017, not timed revealed C6's Roxanol was increased to 10 mg or 0.5 cc every one hour as needed for shortness of breath, pain or restlessness. The Nurses Progress Notes dated March 5, 2017, at 8:15 a.m. established C6 died on March 5, 2017, at 7:55 a.m. The last entry made in C6's narcotic log book indicated there was 25.5 ml of Roxanol remaining in the vial. Review of the licensee's Individual Narcotic Record log under Disposition of Unused Drug was dated August 23, 2017. The licensee waited five months following C6's death before reconciling Roxanol, a controlled substance. An interview with registered nurse (RN)-O on August 31, 2017, at 1:45 p.m. established after C6 died on March 5, 2017, the Roxanol vial was placed back in the double locked box on the medication cart. The licensee maintained an untitled log that contained two staff signatures at the change of shift but not the specific amount and name of the discontinued narcotic medication being reconciled. There was no way to track when the Roxanol could not be accounted for. The first opportunity RN-O had to reconcile and destroy narcotic medications following C6's death on March 5, 2017, was on August 23, 2017. At that time, the vial of C6's Roxanol was empty with 25.5 cc of the medication unaccounted for. RN-O confirmed the narcotic medication should have been destroyed soon after C6's death. RN-O said	0 900		

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0 900	Continued From page 11 after five months the liquid could have evaporated or was diverted. On August 31, 2017, at 2:30 p.m. observation was made of the medication storage for the two wings in the licensee's building. Each wing centrally stored the clients medications in a medication cart with a secured double locked storage for narcotic medications. Two staff conducted narcotic medication counts at the change of every shift. With the discontinuation of narcotic medications, staff continued to reconcile the medication until two licensed staff documented and destroyed the medication. An interview with home health aide (HHA)-P and HHA-Q on August 31, 2017, at 3:00 p.m. established during medication reconciliation both staff ensured the box containing the Roxanol vial was in the locked box. HHA-P and HHA-Q did not check the vial for exact amount of medication remaining in the vial. An interview with licensed practical nurse (LPN)-R on August 31, 2017, at 5:20 p.m. confirmed she gave C6 the last dose of Roxanol before C6 died. LPN-R said she gave 0.5 cc or 10 mg of Roxanol to C6 sublingually or under the tongue. LPN-R documented the amount of Roxanol left in the vial or 25.5 cc. The medication was locked in the medication cart following dispensing the medication to C6. During the medication count after C6 died, LPN-R said staff only signed that the box of Roxanol was in the locked box not the amount of liquid left in the vial. Review of the licensee's policy and procedure titled Narcotic Log with an effective date of November 11, 2015, stated all controlled substances will be counted and recorded on the	0 900		

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0 900	Continued From page 12 narcotic count sheet and compared with quantities listed in the Narcotic Log Book. This will occur with two staff, one at the end a shift and one staff at the beginning of the next shift. Discontinued controlled substances will continue to be counted with the regular narcotic inventory until they can be destroyed according to established procedures. When requested, no policy or procedure was provided regarding the parameters for the reconciliation and destruction of controlled narcotic medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. The violation occurred 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 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). Findings include: C6's medical record was reviewed. C6's home health aide assignment sheet dated November 20, 2017, revealed C6 received comprehensive home care services from the licensee including medication management. Review of the licensee's Medication and Treatment Orders form established on February 28, 2017, the licensee received a physician's	0 900		

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0 900	Continued From page 13 order for C6 to receive Roxanol liquid, a morphine or narcotic medication. The order directed staff to dispense five to ten milligrams (mg) or 0.25 to 0.5 cubic centimeter (cc) every two hours as needed for pain, shortness of breath or restlessness. In addition, on March 4, 2017, there was an order for C6 to receive hospice care. Review of the licensee's Individual Narcotic Record form dated March 1, 2017, revealed the licensee received the Roxanol 20 mg/milliliter (ml) in a 30 ml vial. C6 received a total of 11 doses from March 3, 2017, until March 5, 2017, at 7:30 a.m. The documentation revealed following the last dose of Roxanol, there was 25.5 ml of Roxanol remaining in the vial. Review of the Hospice Medical Practitioner's Orders from dated March 4, 2017, not timed revealed C6's Roxanol was increased to 10 mg or 0.5 cc every one hour as needed for shortness of breath, pain or restlessness. The Nurses Progress Notes dated March 5, 2017, at 8:15 a.m. established C6 died on March 5, 2017, at 7:55 a.m. The last entry made in C6's narcotic log book indicated there was 25.5 ml of Roxanol remaining in the vial. Review of the licensee's Individual Narcotic Record log under Disposition of Unused Drug was dated August 23, 2017. The licensee waited five months following C6's death before reconciling Roxanol, a controlled substance. An interview with registered nurse (RN)-O on 8/31/2017, at 1:45 p.m. established after C6 died on March 5, 2017, the Roxanol vial was placed back in the double locked box on the medication cart. The licensee maintained an untitled log that	0 900		

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0 900	Continued From page 14 contained two staff signatures at the change of shift but not the specific amount and name of the discontinued narcotic medication being reconciled. There was no way to track when the Roxanol could not be accounted for. The first opportunity RN-O had to reconcile and destroy narcotic medications following C6's death on March 5, 2017, was on August 23, 2017. At that time, the vial of C6's Roxanol was empty with 25.5 cc of the medication unaccounted for. RN-O confirmed the narcotic medication should have been destroyed soon after C6's death. RN-O said after five months the liquid could have evaporated or was diverted. On 8/31/2017, at 2:30 p.m. observation was made of the medication storage for the two wings in the licensee's building. Each wing centrally stored the clients medications in a medication cart with a secured double locked storage for narcotic medications. Two staff conducted narcotic medication counts at the change of every shift. With the discontinuation of narcotic medications, staff continued to reconcile the medication until two licensed staff documented and destroyed the medication. An interview with home health aide (HHA)-P and HHA-Q on August 31, 2017, at 3:00 p.m. established during medication reconciliation both staff ensured the box containing the Roxanol vial was in the locked box. HHA-P and HHA-Q did not check the vial for exact amount of medication remaining in the vial. An interview with licensed practical nurse (LPN)-R on August 31, 2017, at 5:20 p.m. confirmed she gave C6 the last dose of Roxanol before C6 died. LPN-R said she gave 0.5 cc or 10 mg of Roxanol to C6 sublingually or under the	0 900		

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0 900	Continued From page 15 tongue. LPN-R documented the amount of Roxanol left in the vial or 25.5 cc. The medication was locked in the medication cart following dispensing the medication to C6. During the medication count after C6 died, LPN-R said staff only signed that the box of Roxanol was in the locked box not the amount of liquid left in the vial. Review of the licensee's policy and procedure titled Narcotic Log with an effective date of November 11, 2015, stated all controlled substances will be counted and recorded on the narcotic count sheet and compared with quantities listed in the Narcotic Log Book. This will occur with two staff, one at the end a shift and one staff at the beginning of the next shift. Discontinued controlled substances will continue to be counted with the regular narcotic inventory until they can be destroyed according to established procedures. When requested, no policy or procedure was provided regarding the parameters for the reconciliation and destruction of controlled narcotic medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 900		
0 905 SS=D	144A.4792, Subd. 2 Provision of Medication Mgt Services Subd. 2. Provision of medication management services. (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37	0 905		

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0 905	Continued From page 16 conduct an assessment ot determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indciations for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications. "Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observations, document review and interview, the licensee failed to provide timely reconciliation and destruction of a narcotic medication in order to prevent drug diversion for one of two (C6) clients discharged record reviewed. The violation occurred 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 pattern scope (when more than a limited number of clients are affected, more than	0 905		

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0 905	Continued From page 17 a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). Findings include: C6's medical record was reviewed. C6's home health aide assignment sheet dated November 20, 2017, revealed C6 received comprehensive home care services from the licensee including medication management. Review of the licensee's Medication and Treatment Orders form established on February 28, 2017, the licensee received a physician's order for C6 to receive Roxanol liquid, a morphine or narcotic medication. The order directed staff to dispense five to ten milligrams (mg) or 0.25 to 0.5 cubic centimeter (cc) every two hours as needed for pain, shortness of breath or restlessness. In addition, on March 4, 2017, there was an order for C6 to receive hospice care. Review of the licensee's Individual Narcotic Record form dated March 1, 2017, revealed the licensee received the Roxanol 20 mg/milliliter (ml) in a 30 ml vial. C6 received a total of 11 doses from March 3, 2017, until March 5, 2017, at 7:30 a.m. The documentation revealed following the last dose of Roxanol, there was 25.5 ml of Roxanol remaining in the vial. Review of the Hospice Medical Practitioner's Orders from dated March 4, 2017, not timed revealed C6's Roxanol was increased to 10 mg or 0.5 cc every one hour as needed for shortness of breath, pain or restlessness. The Nurses Progress Notes dated March 5, 2017, at 8:15 a.m. established C6 died on March	0 905		

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0 905	Continued From page 18 5, 2017, at 7:55 a.m. The last entry made in C6's narcotic log book indicated there was 25.5 ml of Roxanol remaining in the vial. Review of the licensee's Individual Narcotic Record log under Disposition of Unused Drug was dated August 23, 2017. The licensee waited five months following C6's death before reconciling Roxanol, a controlled substance. An interview with registered nurse (RN)-O on August 31, 2017, at 1:45 p.m. established after C6 died on March 5, 2017, the Roxanol vial was placed back in the double locked box on the medication cart. The licensee maintained an untitled log that contained two staff signatures at the change of shift but not the specific amount and name of the discontinued narcotic medication being reconciled. There was no way to track when the Roxanol could not be accounted for. The first opportunity RN-O had to reconcile and destroy narcotic medications following C6's death on March 5, 2017, was on August 23, 2017. At that time, the vial of C6's Roxanol was empty with 25.5 cc of the medication unaccounted for. RN-O confirmed the narcotic medication should have been destroyed soon after C6's death. RN-O said after five months the liquid could have evaporated or was diverted. On August 31, 2017, at 2:30 p.m. observation was made of the medication storage for the two wings in the licensee's building. Each wing centrally stored the clients medications in a medication cart with a secured double locked storage for narcotic medications. Two staff conducted narcotic medication counts at the change of every shift. With the discontinuation of narcotic medications, staff continued to reconcile the medication until two licensed staff	0 905		

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0 905	Continued From page 19 documented and destroyed the medication. An interview with home health aide (HHA)-P and HHA-Q on August 31, 2017, at 3:00 p.m. established during medication reconciliation both staff ensured the box containing the Roxanol vial was in the locked box. HHA-P and HHA-Q did not check the vial for exact amount of medication remaining in the vial. An interview with licensed practical nurse (LPN)-R on August 31, 2017, at 5:20 p.m. confirmed she gave C6 the last dose of Roxanol before C6 died. LPN-R said she gave 0.5 cc or 10 mg of Roxanol to C6 sublingually or under the tongue. LPN-R documented the amount of Roxanol left in the vial or 25.5 cc. The medication was locked in the medication cart following dispensing the medication to C6. During the medication count after C6 died, LPN-R said staff only signed that the box of Roxanol was in the locked box not the amount of liquid left in the vial. Review of the licensee's policy and procedure titled Narcotic Log with an effective date of November 11, 2015, stated all controlled substances will be counted and recorded on the narcotic count sheet and compared with quantities listed in the Narcotic Log Book. This will occur with two staff, one at the end a shift and one staff at the beginning of the next shift. Discontinued controlled substances will continue to be counted with the regular narcotic inventory until they can be destroyed according to established procedures. When requested, no policy or procedure was provided regarding the parameters for the reconciliation and destruction of controlled narcotic medications.	0 905		

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0 905	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 905		
0 935 SS=E	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to administer medications as directed for two of five clients (C1, C5) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 935		

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0 935	Continued From page 21 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1's medical record was reviewed. C1's service plan dated June 10, 2017 indicated C1 required assistance with dressing/grooming, bathing, incontinence care and medication administration. C1's Medication Administration Record dated June 2017, indicated C1 had a medication order for Potassium 20 miliequivalents three times a day. C1's potassium was omitted June 19, 2017 through June 30, 2017, a total of 35 doses. The reason for omission was pharmacy had not delivered. C1's record lacked documentation C1's physician was updated after missing 35 doses of potassium. C1's record also lacked record of any laboratory work completed while receiving services at the licensee. C1's progress notes were reviewed. On July 24, 2017, C1 experienced a fall while standing with ULP-E. C1 fell onto his bottom. July 25, 2017, C1 stated he had lower back pain and was sent to urgent care. C1 had negative back X-rays and returned to the licensee with as needed pain medication. On July 28.2017, C1 died at the licensee while toileting. C1's death record indicated cause of death was vascular. During an interview on September 1, 2017, at	0 935		

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0 935	Continued From page 22 2:35 p.m. director of nursing (DON)-A stated C1's medications had not arrived from the pharmacy yet. C1's medications arrived by mail and took a while to process once ordered. The licensee tried to get the medication filled through a local pharmacy, but C1's guardian would had to pay for it or the guardian could pick it up from the clinic. DON-A stated the guardian was not willing to do either, therefore was the facility had no choice but to wait for the medication to arrive. On September 13, 2017 at 9:30 a.m., C1's guardian stated s/he was unaware C1 had missed any doses of potassium and C1 was unable to keep track of his/her medications. She was never contacted by the licensee when the C1's potassium supply was out, only when over-the-counter medications were low as she provided those. C5's medical record was reviewed. C5's services plan dated August 14, 2017 indicated C5 required total assistance with all activities of daily living, assist of two staff and a total mechanical lift for transfers and medication administration. C5 had a history of psychiatric behaviors including an inpatient hospitalization in a psychiatric unit. A physician progress note dated August 19, 2017, dictated C5 began a decline in health status as indicated by increased weakness and decreased verbalization. Guardian and licensee were coordinating a hospice intake. C5's physician orders were reviewed. On August 23, 2016, Clonazepam 0.5 milligrams (mg) daily at bedtime was started for anxiety. October 25, 2016, Risperidone (antipsychotic) injection every	0 935		

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0 935	Continued From page 23 two was stopped. December 15, 2016 scheduled lorazepam (anti-anxiety) was changed to as needed and scheduled Clonazepam was increased from 0.5 mg to 1 mg. A physician progress noted dated December 27, 2016, dictated C5 had further declined evidenced by physical frailty and significant dementation. The physician dictated there was no indication of understanding conversations. C5 required a longer lasting anxiety control, hence the discontinuation of scheduled lorazepam and increase of Clonazepam. C5's medication administration record (MAR) was reviewed. Clonazepam was omitted due to no medication supply for the following dates: June 10, 2017 through June 14, 2017 June 30, 2017 through July 17, 2017 July 19, 2017 August 4, 2017 and August 5, 2017 C5's progress note dated August 5, 2017, dictated licensed practical nurse (LPN)-B contacted hospice and the pharmacy regarding no medication supply. During an interview on September 13, 2017 at 2:15 p.m., LPN-B stated she heard about the missing Clonazepam during morning report and called the pharmacy immediately. The pharmacy required a new prescription from C5's physician. She messaged C5's physician electronically and requested a new script. A few days later, the Clonazepam still had not arrived and she called both the pharmacy and hospice. LPN-B stated shortly after that phone call the medication was delivered. LPN-B stated when the pharmacy cannot refill a medication for any reason, such needing a new prescription, the pharmacy sends	0 935		

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0 935	Continued From page 24 a bright colored sheet to notify the facility in the evening medication delivery. LPN-B stated the home health aide staff are supposed to leave those slips for the nurses, but the nurses do not always receive the slips from the aides right away. The licensee policy titled "General Policies in Administering Medications" dated October 21, 2007, indicated a medication error includes medication omissions, a medication error report will be filled out and reported to the nurse. TIME PERIOD OF CORRECTION: 21 days	0 935		
01010 SS=D	144A.4792, Subd. 22 Disposition of Medications Subd. 22. Disposition of medications. (a) Any current medications being managed by the comprehensive home care provider must be given to the client or the client's representative when the client's service plan ends or medication management services are no longer part of the service plan. Medications that have been stored in the client's private living space for a client who is deceased or that have been discontinued or that have expired may be given to the client or the client's representative for disposal. (b) The comprehensive home care provider will dispose of any medications remaining with the comprehensive home care provider that are discontinued or expired or upon the termination of the service contract or the client's death according to state and federal regulations for disposition of medications and controlled substances.	01010		

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01010	Continued From page 25 (c) Upon disposition, the comprehensive home care provider must document in the client's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observations, document review and interview, the licensee failed to provide timely reconciliation and destruction of a narcotic medication in order to prevent drug diversion for one of two (C6) clients discharged record reviewed. The violation occurred 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 pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). Findings include: C6's medical record was reviewed. C6's home health aide assignment sheet dated November 20, 2017, revealed C6 received comprehensive home care services from the licensee including medication management. Review of the licensee's Medication and	01010		

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01010	Continued From page 26 Treatment Orders form established on February 28, 2017, the licensee received a physician's order for C6 to receive Roxanol liquid, a morphine or narcotic medication. The order directed staff to dispense five to ten milligrams (mg) or 0.25 to 0.5 cubic centimeter (cc) every two hours as needed for pain, shortness of breath or restlessness. In addition, on March 4, 2017, there was an order for C6 to receive hospice care. Review of the licensee's Individual Narcotic Record form dated March 1, 2017, revealed the licensee received the Roxanol 20 mg/milliliter (ml) in a 30 ml vial. C6 received a total of 11 doses from March 3, 2017, until March 5, 2017, at 7:30 a.m. The documentation revealed following the last dose of Roxanol, there was 25.5 ml of Roxanol remaining in the vial. Review of the Hospice Medical Practitioner's Orders from dated March 4, 2017, not timed revealed C6's Roxanol was increased to 10 mg or 0.5 cc every one hour as needed for shortness of breath, pain or restlessness. The Nurses Progress Notes dated March 5, 2017, at 8:15 a.m. established C6 died on March 5, 2017, at 7:55 a.m. The last entry made in C6's narcotic log book indicated there was 25.5 ml of Roxanol remaining in the vial. Review of the licensee's Individual Narcotic Record log under Disposition of Unused Drug was dated August 23, 2017. The licensee waited five months following C6's death before reconciling Roxanol, a controlled substance. An interview with registered nurse (RN)-O on August 31, 2017, at 1:45 p.m. established after C6 died on March 5, 2017, the Roxanol vial was	01010		

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01010	Continued From page 27 placed back in the double locked box on the medication cart. The licensee maintained an untitled log that contained two staff signatures at the change of shift but not the specific amount and name of the discontinued narcotic medication being reconciled. There was no way to track when the Roxanol could not be accounted for. The first opportunity RN-O had to reconcile and destroy narcotic medications following C6's death on March 5, 2017, was on August 23, 2017. At that time, the vial of C6's Roxanol was empty with 25.5 cc of the medication unaccounted for. RN-O confirmed the narcotic medication should have been destroyed soon after C6's death. RN-O said after five months the liquid could have evaporated or was diverted. On August 31, 2017, at 2:30 p.m. observation was made of the medication storage for the two wings in the licensee's building. Each wing centrally stored the clients medications in a medication cart with a secured double locked storage for narcotic medications. Two staff conducted narcotic medication counts at the change of every shift. With the discontinuation of narcotic medications, staff continued to reconcile the medication until two licensed staff documented and destroyed the medication. An interview with home health aide (HHA)-P and HHA-Q on August 31, 2017, at 3:00 p.m. established during medication reconciliation both staff ensured the box containing the Roxanol vial was in the locked box. HHA-P and HHA-Q did not check the vial for exact amount of medication remaining in the vial. An interview with licensed practical nurse (LPN)-R on August 31, 2017, at 5:20 p.m. confirmed she gave C6 the last dose of Roxanol	01010		

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01010	Continued From page 28 before C6 died. LPN-R said she gave 0.5 cc or 10 mg of Roxanol to C6 sublingually or under the tongue. LPN-R documented the amount of Roxanol left in the vial or 25.5 cc. The medication was locked in the medication cart following dispensing the medication to C6. During the medication count after C6 died, LPN-R said staff only signed that the box of Roxanol was in the locked box not the amount of liquid left in the vial. Review of the licensee's policy and procedure titled Narcotic Log with an effective date of November 11, 2015, stated all controlled substances will be counted and recorded on the narcotic count sheet and compared with quantities listed in the Narcotic Log Book. This will occur with two staff, one at the end a shift and one staff at the beginning of the next shift. Discontinued controlled substances will continue to be counted with the regular narcotic inventory until they can be destroyed according to established procedures. When requested, no policy or procedure was provided regarding the parameters for the reconciliation and destruction of controlled narcotic medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01010		
01090 SS=D	144A.4794, Subd. 5 Record Retention Subd. 5. Record retention. Following the client's discharge or termination of services, a home care provider must retain a client's record for at least five years, or as otherwise required by state or federal regulations. Arrangements must be made for	01090		

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01090	Continued From page 29 secure storage and retrieval of client records if the home care provider ceases business. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to retain fax communication records for one of five clients (C1) reviewed. This practice resulted in a level two 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 admitted to the licensee on June 7, 2017. C1's service plan dated June 10, 2017 indicated C1 required assistance with dressing/grooming, bathing, incontinence care and medication administration. C1's Medication Administration Record dated June 2017, indicated C1 had a medication order for Potassium 20 miliequivalents three times a day. C1's potassium was omitted June 20, 2017 through June 30, 2017, a total of 32 doses. C1's record lacked documentation C1's physician was updated after missing 32 doses of potassium. C1's record also lacked record of any laboratory work completed while receiving services at the licensee. C1's progress notes were reviewed. On July 28.2017, C1 died at the licensee.	01090		

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01090	Continued From page 30 During an interview on September 1, 2017, at 2:35 p.m. director of nursing (DON)-A stated C1's physician was updated on the medication omission, but the fax records were no longer available after C1 passed away. The licensee policy titled "Resident Record Retention" dated December 8, 2015, indicated client records will be retained for seven years after termination of services. TIME PERIOD OF CORRECTION: 21 days	01090		