MDH Minnesota Department of Health

## Office of Health Facility Complaints Investigative Report
**PUBLIC**

| Facility Name: | Report Number: | Date of Visit: |
|---|---|---|
| Sunrise Assisted Living of Roseville | HL22361003 | June 23 and 27, 2016 |
| **Facility Address:** | **Time of Visit:** | **Date Concluded:** |
| 2555 Snelling Avenue North | 9:45 a.m. - 3:30 p.m. and 8:30 a.m. - 2:30 p.m. | November 28, 2016 |
| **Facility City:** | **Investigator's Name and Title:** | |
| Roseville | Darin Hatch | |

| State: | ZIP: | County: |
|---|---|---|
| Minnesota | 55113 | Ramsey |

☒ **Home Care Provider/Assisted Living**

### Allegation(s):

It is alleged that seven clients were financially exploited when staff, alleged perpetrator (AP), took the client's medications.

☒ 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 is substantiated. The alleged perpetrator (AP) took pain medications belonging to seven different clients over the course of multiple incidents.

All seven clients received medication administration from the home care provider. Client #1 had a physician's order for morphine 5 milligrams (mg). Client #2 had a physician's order for tramadol 50 mg. Client #3 had a physician's order for hydrocodone/APAP 5/325 mg. Client #4 had a physician's order for oxycodone 2.5 mg (5 mg, half tablets). Client #5 had a physician's order for oxycodone 5 mg. Client #6 had a physician's order for hydrocodone/APAP 5/325 mg (half tablets). Client #7 had a physician's order for hydrocodone/APAP 5/325 mg.

Interviews with staff were conducted. A nurse tried to refill the physician's order for Client #7. The pharmacy called back later and told the nurse that it was too soon to refill the order. The nurse reviewed the facility medication administration records and the original physician's order and determined Client #7 should have 30 tablets remaining. When checking the narcotic count sheet, the nurse noticed the AP had logged in the narcotic medications. This was unusual because the nurse received the medications from the pharmacy and always logged the medications in after receiving them from the pharmacy. The nurse notified the supervisor.

A review of the pharmacy delivery inventory sheets and the narcotic count book sheets revealed the following missing medications for each client: Client #1 had 30 tablets of morphine 5 mg missing; Client #2 had 30 tablets of tramadol 50 mg missing; Client #3 had 150 tablets of hydrocodone/APAP 5/325 missing; Client #4 had 120 half tablets of oxycodone 2.5 mg (5 mg half tablets) missing; Client #5 had 60 half tablets

of oxycodone missing: Client #6 had 90 half tablets of hydrocodone/APAP 5/325 mg missing; and Client #7 had 90 tablets of hydrocodone/acetaminophen 5/325 mg missing.

The AP had falsified signatures, altered count documents, and falsified count inventory numbers and dates for all seven clients. Staff checked the document destruction bins and discovered empty bubble packs for Client #3, Client #4, and Client #5 along with what appeared to be practice pages of staff signatures. The AP confessed s/he was responsible for all the missing medications to management.

A police report indicated police were notified by the home care provider that medications were missing. The home care provider provided police with documentation detailing the missing medications. The police interviewed the AP, and the AP admitted to taking medications from the clients.

The AP was interviewed and admitted to taking the medications from the clients.

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 home care provider had policies in place to prevent financial exploitation. 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 facility is also responsible for the financial exploitation because they failed to implement a system for the control of narcotic medications.

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:**

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**Facility Corrective Action:**

The facility took the following corrective action(s):

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**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
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Care Plan Records
- ☒ Facility Incident Reports
- ☒ ADL (Activities of Daily Living) Flow Sheets

☒ Service Plan

**Other pertinent medical records:**

☒ Police Report

**Additional facility records:**

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☒ 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 records selected

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: _____

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: 6

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

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

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**

**Roseville Police Department**

**Ramsey County Attorney**

**Roseville 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 |
|---|---|---|---|
| | H22361 | A. BUILDING: _____ B. WING _____ | C 07/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNRISE ASSTD LIV OF ROSEVILLE | 2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113 |

| (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 |
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| 0 000 | Initial Comments<br><br>*****ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are been issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On June 27, 2016, a complaint investigation was initiated to investigate complaint #HL22361003. At the time of the survey, there were 82 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 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2) | |
| 0 325 | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: | 0 325 | | |

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| 0 325 | Continued From page 1<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on document review and interview, the licensee failed to ensure that seven of seven clients (C1), (C2), (C3), (C4), (C5), (C6), and (C7) reviewed were free from maltreatment when they were financially exploited by licensed practical nurse (LPN)-M who stole the client's narcotic medications.<br><br>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:<br><br>C1's file was reviewed. C1 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated February 25, 2016. C1 had a physician's order dated January 4, 2016 for morphine, 5 milligrams (mg), 1 tablet as needed every hour and a physician's order dated April 7, 2016 for morphine 5 mg, 1 tablet twice daily.<br><br>C2's file was reviewed. C2 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 1, 2016. C2 had a physician's order dated March 15, 2016 for | 0 325 | | |

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| 0 325 | Continued From page 2<br>tramadol, 50 mg three times daily, and one time daily as needed.<br><br>C3's file was reviewed. C3 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 21, 2016. C3 had a physician's order dated April 19, 2016 for hydrocodone/APAP 5/325, 1 tablet four times daily and twice daily as needed.<br><br>C4's file was reviewed. C4 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 17, 2016. C4 had a physician's order dated April 19, 2016 for oxycodone 2.5 mg (5 mg half tablets), 1 half tablet three times daily and 1 half tablet every four hours as needed.<br><br>C5's file was reviewed. C5 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated February 25, 2016. C5 had a physician's order dated April 17, 2016 for oxycodone 5 mg (5 mg half tablets), 1 tablet one time daily and 1 half tablet three times daily as needed.<br><br>C6's file was reviewed. C6 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 17, 2016. C6 had a physician's order dated December 24, 2015 for hydrocodone/APAP 5/325 mg (half tablets) 1 half tablet one time daily and 1 half tablet three times daily as needed.<br><br>C7's file was reviewed. C7 received medication administration from the comprehensive home | 0 325 | | |

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| 0 325 | Continued From page 3<br>care provider according to a service agreement and care plan dated March 10, 2016. C7 had a physician's order dated March 1, 2016 for hydrocodone/APAP 5/325 mg, 1 tablet four times daily, and 2 tablets as needed one time daily.<br><br>Interview with LPN-A on June 27, 2016 at 1:02 p.m. revealed on May 16, 2016 LPN-A tried to refill the physician's order for C7 for hydrocodone/APAP 5/325 mg as she noticed C7 was getting low on the medication. The pharmacy called back later and told LPN-A that it was too soon to refill the order. LPN-A reviewed the facility medication administration records and the original physician's order and determined C7 should have an additional card of 30 tablets remaining. When checking the narcotic count she noticed LPN-M had signed her name as the person who logged in the narcotic medications. LPN-A said she always signs for the medications from the pharmacy and logs them in the narcotic book herself. She said it was unusual for her to sign for receipt of the medications but not sign the narcotic log in book. LPN-A said LPN-M had signed the narcotic log book so LPN-A and LPN-M went to notify registered nurse (RN)-C of the 30 tablet shortage.<br><br>Interview with RN-C on June 27, 2016 revealed LPN-A came to her on May 16, 2016 and told her that when she tried to refill the physician's order for C7 the pharmacy said it was too soon to refill the order. She said LPN-A did some research and determined C7 should have an additional card of 30 tablets of hydrocodone/APAP 5/325 mg remaining. LPN-A also told her she noticed LPN-M had logged the order in the narcotic count book for the order LPN-A received from the pharmacy and that was unusual. RN-C said she began investigating by checking the pharmacy | 0 325 | | |

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| 0 325 | Continued From page 4<br>delivery inventory sheets with the narcotic count book sheets and noticed the following missing medications per client: C1-30 tablets of morphine 5 mg missing; C2-30 tablets of tramadol 50 mg missing; C3-150 tablets of hydrocodone/APAP 5/325 missing; C4-120 half tablets of oxycodone 2.5 mg (5 mg half tablets) missing; C5-60 half tablets of oxycodone 2.5 mg (5 mg half tablets) missing: C6-90 half tablets of hydrocodone/APAP 5/325 mg (half tablets) missing; C7-90 tablets of hydrocodone/APAP 5/325 mg missing. RN-C said her review of the delivery inventory sheets and narcotic count book sheets revealed LPN-M had falsified signatures, altered count documents, and falsified count inventory numbers and dates for all seven clients. RN-C said as part of her investigation she also checked the document destruction bins and discovered empty bubble packs for C3, C4, and C5 along with what appeared to be practice pages of staff signatures. RN-C said she was in the executive director's office when LPN-M came in and admitted she was responsible for all the missing medications.<br><br>An employee handbook dated April 2013 indicates on page 15 that "Sunrise is committed to complying with the laws and regulations to which we are subject." The handbook indicates on page 21 that "Sunrise is committed to providing an environment where residents remain free from abuse, neglect, and other exploitation."<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 325 | | |
| 0 900 | 144A.4792, Subd. 1 Medication Management; Comprehensive | 0 900 | | |

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| 0 900 | Continued From page 5<br><br>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.<br><br>(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.<br><br>(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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| 0 900 | Continued From page 6<br>medications. When controlled substances are being<br>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<br>with state and federal regulations and with subdivision 22.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to implement a system for the control of narcotic medications for seven of seven clients (C1), (C2), (C3), (C4), (C5), (C6), and (C7) 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:<br><br>Observations conducted during the onsite visit revealed client controlled substance medications are centrally stored double locked in a medication cart, one on each floor. Only trained or licensed staff are allowed to administer the controlled substance medications and only trained or licensed staff have a key to access the controlled substance medications. There was one set of keys belonging to trained or 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 trained or licensed staff received and signed for | 0 900 | | |

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| 0 900 | Continued From page 7<br>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, when a medication card is emptied, two staff are required to verify the empty card and update the narcotic count book.<br><br>C1's file was reviewed. C1 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated February 25, 2016. C1 had a physician's order dated January 4, 2016 for morphine, 5 milligrams (mg), 1 tablet as needed every hour and a physician's order dated April 7, 2016 for morphine 5 mg, 1 tablet twice daily.<br><br>C2's file was reviewed. C2 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 1, 2016. C2 had a physician's order dated March 15, 2016 for tramadol, 50 mg three times daily, and one time daily as needed.<br><br>C3's file was reviewed. C3 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 21, 2016. C3 had a physician's order dated April 19, 2016 for hydrocodone/APAP 5/325, 1 tablet four times daily and twice daily as needed.<br><br>C4's file was reviewed. C4 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 17, 2016. C4 had a physician's order dated April 19, 2016 for oxycodone 2.5 mg (5 mg half tablets), 1 half | 0 900 | | |

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| 0 900 | Continued From page 8<br>tablet three times daily and 1 half tablet every four hours as needed.<br><br>C5's file was reviewed. C5 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated February 25, 2016. C5 had a physician's order dated April 17, 2016 for oxycodone 5 mg (5 mg half tablets), 1 tablet one time daily and 1 half tablet three times daily as needed.<br><br>C6's file was reviewed. C6 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 17, 2016. C6 had a physician's order dated December 24, 2015 for hydrocodone/APAP 5/325 mg (half tablets) 1 half tablet one time daily and 1 half tablet three times daily as needed.<br><br>C7's file was reviewed. C7 received medication administration from the comprehensive home care provider according to a service agreement and care plan dated March 10, 2016. C7 had a physician's order dated March 1, 2016 for hydrocodone/APAP 5/325 mg, 1 tablet four times daily, and 2 tablets as needed one time daily.<br><br>Interview with LPN-A on June 27, 2016 at 1:02 p.m. revealed on May 16, 2016 LPN-A tried to refill the physician's order for C7 for hydrocodone/APAP 5/325 mg as she noticed C7 was getting low on the medication. The pharmacy called back later and told LPN-A that it was too soon to refill the order. LPN-A reviewed the facility medication administration records and the original physician's order and determined C7 should have an additional card of 30 tablets remaining. When checking the narcotic count | 0 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | H22361 | A. BUILDING: _____ B. WING _____ | C 07/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUNRISE ASSTD LIV OF ROSEVILLE | 2555 SNELLING AVENUE NORTH ROSEVILLE, MN 55113 |

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| 0 900 | Continued From page 9<br><br>she noticed LPN-M had signed her name as the person who logged in the narcotic medications. LPN-A said she always signs for the medications from the pharmacy and logs them in the narcotic book herself. She said it was unusual for her to sign for receipt of the medications but not sign the narcotic log in book. LPN-A said LPN-M had signed the narcotic log book so LPN-A and LPN-M went to notify registered nurse (RN)-C of the 30 tablet shortage.<br><br>Interview with RN-C on June 27, 2016 revealed LPN-A came to her on May 16, 2016 and told her that when she tried to refill the physician's order for C7 the pharmacy said it was too soon to refill the order. She said LPN-A did some research and determined C7 should have an additional card of 30 tablets of hydrocodone/APAP 5/325 mg remaining. LPN-A also told her she noticed LPN-M had logged the order in the narcotic count book for the order LPN-A received from the pharmacy and that was unusual. RN-C said she began investigating by checking the pharmacy delivery inventory sheets with the narcotic count book sheets and noticed the following missing medications per client: C1-30 tablets of morphine 5 mg missing; C2-30 tablets of tramadol 50 mg missing; C3-150 tablets of hydrocodone/APAP 5/325 missing; C4-120 half tablets of oxycodone 2.5 mg (5 mg half tablets) missing; C5-60 half tablets of oxycodone 2.5 mg (5 mg half tablets) missing: C6-90 half tablets of hydrocodone/APAP 5/325 mg missing; C7-90 tablets of hydrocodone/APAP 5/325 mg missing. RN-C said her review of the delivery inventory sheets and narcotic count book sheets revealed LPN-M had falsified signatures, altered count documents, and falsified count inventory numbers and dates for all seven clients. RN-C said as part of her investigation she also checked the document | 0 900 | | |

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| 0 900 | Continued From page 10<br><br>destruction bins and discovered empty bubble packs for C3, C4, and C5 along with what appeared to be practice pages of staff signatures. RN-C said she was in the executive director's office when LPN-M came in and admitted she was responsible for all the missing medications. RN-C said at the time of the incident only one trained or 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, when a medication card is emptied, two staff are required to verify the empty card and update the narcotic count book.<br><br>A policy titled Storage of Medications-Minnesota and dated August 20, 2014 indicates on page 1 "the purpose of this policy and procedure is to ensure that a resident's medication is stored in a safe and secure manner consistent with applicable laws and regulations." In addition page 2 indicates "the RN will also identify in the plan a process for monitoring or tracking controlled medications, or those at risk of diversion. The RN will establish a community specific written process that addresses the storage and handling of medications, including: how medications are received and secured when delivered by the pharmacy, where medications are stored within the community, who is authorized to access medications, how refills and prescription renewals will be monitored, and control measures and procedures to prevent or identify diversion of medication."<br><br>A policy titled Medication Management-Minnesota and dated August 20, 2014 indicates on page 1 the Health Care Coordinator or Registered Nurse | 0 900 | | |

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| 0 900 | Continued From page 11<br>is responsible for the implementation of medication management policies and procedures." In addition on page 2 the policy indicates "the RN will develop, implement, and update as needed specific procedures for following medication management activities: requesting and receiving prescriptions, and controlling and storing medications, including controlled substances.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |