DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Charter House		**Report Number:** H5282006	**Date of Visit:** October 19, 2017
Facility Address: 211 2ND Street NW		**Time of Visit:** 10:00 a.m. to 4:00 p.m.	**Date Concluded:** December 22, 2017
Facility City: Rochester		**Investigator's Name and Title:** Christine Bluhm, RN, Special Investigator	
State: Minnesota	**ZIP:** 55901	**County:** Olmsted	

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was exploited when the alleged perpetrator took the resident's narcotic medication for his/her own use.

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

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

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the alleged perpetrator (AP) took narcotics from a resident at the facility. The AP admitted taking narcotics from several residents.

The resident required care following knee replacement surgery and had a physician's order for narcotic pain medication. The resident was alert and oriented, able to make his/her needs known and dependent on staff for medication delivery.

Discrepancies were noted between the narcotic inventory log and the resident's chart documentation. One of the medications, hydromorphone, had been signed out by the AP as given to the resident but the resident reported his/her pain was controlled and had not requested the hydromorphone that had been signed out as given to him/her during a certain time period. The AP was interviewed by the facility and law enforcement. The police report indicated the AP admitted taking the medications, oxycodone and hydromorphone, from two or three residents within approximately the past four months. The AP stated that s/he never withheld pain medication from a resident.

The AP was interviewed and admitted s/he took hydromorphone from the resident's medication supply for

his/her own use. The AP stated that the resident did not go without pain medication when the resident needed it.

Residents were interviewed at the facility. Residents stated that pain control was adequate with medication and received pain medication when they requested it.

The AP was terminated from the facility.

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 had drug diversion and controlled substance policies in place. The alleged perpetrator was trained on the facility policies.

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

Compliance:

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

Deficiencies are issued on form 2567: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

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

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

(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.

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

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

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to

perform services for the profit or advantage of another.

(c) Nothing in this definition requires a facility or caregiver to provide financial management or supervise financial management for a vulnerable adult except as otherwise required by law.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Social Service Notes
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Other, specify: Narcotic logs

Other pertinent medical records:

- [x] Police Report

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records

☒ Facility Policies and Procedures

☒ Other, specify: Narcotic inventory logs

Number of additional resident(s) reviewed: Two

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

Specify:

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

○ Yes ◉ No ○ N/A

Specify: Resident was discharged to home.

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: Resident was own person.

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

◉ Yes ○ No ○ N/A Specify:

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Four

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A
Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A
Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Rochester Police Department

Olmsted County Attorney

Rochester City Attorney

Board of Nursing
Board of Nursing Home Administrators

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2018

Ms. Cara Tracy, Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

RE: Project Numbers S5282027, H5282006, H5282007

Dear Ms. Tracy:

On January 11, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 16, 2018. (42 CFR 488.422)

Also, on January 11, 2018, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on December 14, 2017, and failure to achieve substantial compliance at the standard survey completed by the Minnesota Departments of Health and Public Safety on December 21, 2017.

On February 8, 2018 and February 12, 2018, the Minnesota Departments of Health, Office of Health Facility Complaints and the Minnesota Department of Health completed a Post Certification Revisits (PCR) and On January 23, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed December 14, 2017 and a standard survey, completed on December 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our surveys, as of February 8, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 8, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245282	A. BUILDING _____ B. WING _____	R-C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on 2/8/18, to follow up on deficiencies issued related to complaint # H5282006 & H5282007. Charter House is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 1, 2018

Ms. Cara Tracy, Administrator
Charter House
211 Northwest Second Street
Rochester, MN 55901

Re: Enclosed Reinspection Results - Complaint Numbers H5282006, H5282007

Dear Ms.. Tracy:

On February 8, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on December 14, 2018. At this time these correction orders were found corrected.

Please note, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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	00193	A. BUILDING: _____ B. WING _____	R-C 02/08/2018

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5282006 & H5282007. Charter House was found in compliance with state regulations.	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/21/18

Minnesota Department of Health

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{2 000}	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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

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	245282	A. BUILDING _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5282006 and #H5282007. As a result, the following deficiencies are issued for H5282006 and H5282007. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a safe transfer for 1 of 3 residents (R2) reviewed by not ensuring the attachment straps on the mechanical ceiling lift were secure during the transfer. One strap became loose and the resident fell from the lift. Harm occured when the R2 sustained a clavicle and rib fracture because of the fall. Findings include: R2's progress note dated 8/7/17 at 11:22 a.m., indicates the resident has a history of stroke with residual right sided weakness and aphasia; communication ability was impaired. R2 required a full body lift for all transfers. R2 was able to use the call light to alert staff for needs. Progress note dated 8/27/17 at 3:47 p.m., Registered Nurse (RN)-D indicated R2 fell from the lift and was on the floor on her right side and right arm, but able to follow commands. R2 stated that her right arm hurt. Per the aides report, R2 had fallen out of the ceiling lift. Hospital radiology note dated 8/27/17 at 5:33 p.m., indicated R2 had moderately displaced right-sided rib fractures and right associated pulmonary contusions, and a right clavicle fracture. R2 was hospitalized for nine days following the fall. After the hospitalization and returning to the facility, a slider sheet/board transfer from bed to special wheelchair was implemented and the mechanical ceiling lift was no longer used eliminating any fear or anxiety it could cause R2.	F 323		

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F 323	Continued From page 2 When interviewed on 11/7/17 at 12:40 p.m., Nursing Assistant (NA)-A stated that when the lift in R2's room was on the curved part of the track, it 'sticks.' After the curve, the transfer resumed, and the loop popped out by R2's head, and R2 fell out. NA-A stated she did not know what caused the loop to 'pop.' NA-A stated that repositioning of R2's arm occurred at one point during the transfer. NA-A was focused on R2's position in the sling and not the loop placement. On 11/7/17 at 1:20 p.m., NA-C was interviewed and stated that when R2 was being moved around the curve in the ceiling track, R2 said ouch and the transfer was stopped. R2 told staff they needed to move her right arm. Getting past the curve point in the track required more force and a little harder push. The transfer resumed and NA-C noted a 'jerk' in the lift, so they moved the lift backward a foot and then forward again. As they moved forward, R2 started to fall with the right side of the sling falling first. NA-C stated the lift loops were secure after repositioning R2's arm because R2 remained in an upright position. On 11/7/17 at 3:10 p.m., NA-B stated that during the transfer activity, staff were talking about non-transfer related things. She witnessed staff adjusting R2's arm in the bathroom, right over the toilet. She did not see any loops loose at that time but could not verify if she looked at them during the entire transfer. NA-B remembers thinking the gap in the track at the bathroom door was big and had never seen a gap that big in a track before. NA-B believed the lift got hooked in between the gap at the bathroom door making the transfer difficult and does not remember seeing anyone checking the loops and hooks to be secure.	F 323		

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F 323	Continued From page 3 Interview with Safety Coordinator (SC)-E team member on 11/9/17 at 1:05 p.m., SC-E verified that there were no mechanical or defective issues with the sling or lift; observed the sling was in good working order; no frays or cuts in the sling making it inappropriate to use. Interview with RN-D on 11/9/17 at 3:07 p.m., went to R2's room after hearing screams. RN-D saw R2 on the floor and 3 of the 4 loops were still attached to the lift. On 11/7/17 at 2:23 p.m., interview with FM-F stated that he was told the lift was in good working order and the fall had to be related to not being properly hooked up. He has observed staff transfer R2 before and feels they could have performed more supervision during the transfers. On 12/4/17 at 9:35 a.m., interview with FM-G indicated that full lift transfers were observed before and staff many times lifted R2 too high above the ground, lifting R2 as high as the lift would go. FM-G also observed staff being inattentive and conversing about non-transfer related things during transfers and had to remind staff to pay attention to the transfer. In the policy titled Safe Lifting and Movement of Residents, dated 8/22/16, it indicates: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents.	F 323		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)	F 431		

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

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F 431	Continued From page 4 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431		

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	245282	A. BUILDING _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

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F 431	Continued From page 5 controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on document review, and interviews, the facility failed to ensure 1 of 3 residents (R1) reviewed medicautions were secure when a staff member took controlled substance medications from the resident on multiple occasions for their own personal use. Findings include: R1's medical record was reviewed. Per R1's care plan dated 8/21/17, R1 was at risk for pain following a surgical procedure and nursing staff were to provide pain medications as ordered. R1 had a physician's order for Tramadol (narcotic pain medication) 50-100 milligrams (mg) by mouth as needed every six hours, dated 8/19/17. Documentation in the electronic medication record shows R1 received the medication at least once per day during the stay at the facility. R1 also had a physician's order for hydromorphone (narcotic pain medication) 1 mg by mouth as needed every four hours, dated 8/19/17. Documentation from R1's medication	F 431		

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F 431	Continued From page 6 record from 8/20/17 at 12:03 p.m. to 8/23/17 at 8:00 p.m., indicated that there were eight doses of hydromorphone given by five different staff members over all shifts. Documentation from R1's medication record from 8/24/17 at 1:25 a.m. to 8/31/17 at 12:10 a.m., indicated that eight doses of hydromorphone were given by registered nurse (RN)-G all on the night shift. Two of the doses are signed out of the narcotic book but were not signed out in R1's electronic medical record. Four of the eight doses lack a patient reported pain scale. Per interview with RN-B on 10/31/17 at 9:10 a.m., RN-B stated that the facility provided training on reporting suspected drug diversion. Per interview with RN-C on 10/31/17 at 10:26 a.m., RN-C stated that all staff nurses have ongoing education on medication administration and documentation both in the electronic medical record and in the narcotic log book. RN-C also stated that residents were interviewed regarding pain control after noting inconsistencies in the narcotic log. R1 told RN-C that she had not taken hydromorphone in over a week, although it was documented in R1's record that the medication had been removed and signed out by RN-H as given to R1. R1's medication logs, showed discrepancies, lacked pain scales and pain interventions. Per interview with RN-D on 11/8/17 at 3:56 p.m., RN-D noted that a couple of residents were not taking narcotic medications during the overnight shift but the meds were signed out that they did. RN-D then asked the two residents if they had	F 431		

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F 431	Continued From page 7 taken any pain meds. Both residents confirmed they did not take any pain meds overnight. The meds in question were signed out as taken by RN-H. Per interview with RN-E on 11/9/17 at 3:21 p.m., a resident (could not remember resident's name) was adamant that she was given pain medication during the night but it was not effective and didn't believe it was what the pain medication that the nurse (unknown name) said it was. Per interview with R1 on 11/27/17 at 4:53 p.m., R1 stated that her pain was managed primarily with the Tramadol and did not require the hydromorphone. R1 did not go without pain medication when it was needed. On 9-18-17 at 11:30 a.m., police interviewed RN-H. RN-H admitted taking medications from the medication cart. Per the police report, RN-H admitted to diverting medication from residents that didn't want to take their medication. He diverted oxycodone and hydromorphone from at least two residents since approximately April. When interviewed on 12/6/17 at 9:59 a.m., RN-H admitted to taking hydromorphone from R1, but stated no residents, including R1, ever went without their pain medication. Per facility policy titled Controlled Substances, dated 2/6/2017, indicates nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must count and verify the number together. Per policy titled Drug Diversion Reporting and Response dated 7/31/2017, drug diversion is	F 431		

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

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F 431	Continued From page 8 defined as intentionally and without proper authorization, using or taking possession of a prescription medication from Mayo Supplies, Mayo patients, or through the use of Mayo prescription, ordering, or dispensing systems.	F 431		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5282006 and #H5282007. As a result, the following correction order is issued for H5282006. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational	2 000		

Minnesota Department of Health

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2 000	Continued From page 1 Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on document review and interviews, the facility failed to protect 2 of 3 residents (R1) reviewed from maltreatment. R1 was financially	21850		

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21850	Continued From page 2	21850		

exploited when a staff member took controlled medications from the resident on multiple occasions for their own personal use. In addition, R2 was neglected when R2 fell from the ceiling lift. Staff did not supervise the transfer lift process to ensure the loops were secured. Harm

Findings include:

R1's medical document was reviewed. Per the care plan dated 8/21/17, R1 was at risk for pain following a surgical procedure and nursing staff were to provide pain medications as ordered.

R1 had a physician's order for Tramadol (narcotic pain medication) 50-100 milligrams (mg) by mouth as needed every six hours, dated 8/19/17. Documentation in the electronic medication record shows R1 received the medication at least once per day during the stay at the facility. The date and time of each dose of medication given in the electronic record entries correspond to the narcotic log book entries. There were no noted discrepancies.

R1 also had a physician's order for hydromorphone (narcotic pain medication) 1 mg by mouth as needed every four hours, dated 8/19/17. Documentation from R1's medication record from 8/20/17 at 12:03 p.m. to 8/23/17 at 8:00 p.m., there were eight doses given by five different staff members over all shifts.

Documentation from R1's medication record from 8/24/17 at 1:25 a.m. to 8/31/17 at 12:10 a.m., eight doses of medication were given by registered nurse (RN)-G all on the night shift. Two of the doses are signed out of the narcotic book but are not signed out in R1's electronic medical record. Four of the eight doses lack a patient

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21850	Continued From page 3 reported pain scale. Per interview with RN-B on 10/31/17 at 9:10 a.m., RN-B stated that the facility provided training on drug diversion and reporting it if suspected. Per interview with RN-C on 10/31/17 at 10:26 a.m., RN-C stated that all staff nurses have ongoing education on medication administration and documentation both in the electronic medical record and in the narcotic log book. RN-C also stated that residents were interviewed regarding pain control after noting inconsistencies in the narcotic log. When RN-C interviewed R1, R1 clarified that she had not taken hydromorphone in over a week, although it was documented in R1's record that the medication had been removed and signed out by RN-H as given to R1. This led to further review of R1's medication logs, which showed discrepancies, lacked pain scales and pain interventions. Per interview with RN-D on 11/8/17 at 3:56 p.m., it was found that a couple of residents that were not taking narcotic medications during the overnight shift but the meds were signed out that they did. RN-D then asked the two residents if they had taken any pain meds. Both residents confirmed they did not take any pain meds overnight. The meds in question were signed out as taken by RN-H. Per interview with RN-E on 11/9/17 at 3:21 p.m., a resident who was interviewed, was adamant that s/he was given pain medication during the night but it was not effective and didn't believe it was what the pain medication that the nurse (unknown name) said it was. Per interview with R1 on 11/27/17 at 4:53 p.m.,	21850		

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21850	Continued From page 4 R1 stated that his/her pain was managed primarily with the Tramadol and did not require the hydromorphone. R1 did not go without pain medication when it was needed. On 9-18-17, police interviewed RN-H. RN-H admitted taking medications from the medication cart. Per police report # 17-44214, RN-H admitted to diverting medication from residents that didn't want to take their medication. He diverted from at least two residents since approximately April. Per facility policy titled Controlled Substances, dated 2/6/2017, indicates nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must count and verify the number together. Per policy titled Drug Diversion Reporting and Response dated 7/31/2017, drug diversion is defined as intentionally and without proper authorization, using or taking possession of a prescription medication from Mayo Supplies, Mayo patients, or through the use of Mayo prescription, ordering, or dispensing systems. R2's Progress note dated 8/7/17 at 11:22 a.m., indicates the resident has a history of stroke with residual right sided weakness and aphasia; communication ability was impaired. R2 required a full body lift for all transfers. R2 was able to use the call light to alert staff for needs. The lift in R2's room was mounted to a ceiling track with a hand held manual control operated by staff. Progress note dated 8/27/17 at 3:47 p.m., Registered Nurse (RN)-D indicated R2 fell from the lift and was on the floor on her right side and right arm, but able to follow commands. R2 stated	21850		

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21850	Continued From page 5 that her right arm hurt. Per the aides report, R2 had fallen out of the ceiling lift. Hospital radiology note dated 8/27/17 at 5:33 p.m., indicated R1 had moderately displaced right-sided rib fractures and right associated pulmonary contusions, and a right clavicle fracture. R1 was hospitalized for nine days following the fall. After the hospitalization and returning to the facility, a slider sheet/board transfer from bed to special wheelchair was implemented and the mechanical ceiling lift was no longer used eliminating any fear or anxiety it could cause R1. On 11/7/17 at 12:40 p.m., Nursing Assistant (NA)-A stated that when the lift was on the curved part of the track, it 'sticks.' After the curve, the transfer resumed, and the loop popped out by R2's head, and R2 fell out. NA-A stated she did not know what caused the loop to 'pop.' NA-A stated that repositioning of R2's arm occurred at one point. NA-A was focused on R2's position in the sling and not the loop placement. On 11/7/17 at 1:20 p.m., NA-C was interviewed and stated that when R2 was being moved around the curve in the ceiling track, R2 said ouch and the transfer was stopped. R2 told staff they needed to move her right arm. Getting past the curve point in the track required more force and a little harder push. The transfer resumed and NA-C noted a 'jerk' in the lift, so they moved the lift backward maybe a foot and then forward again. As they moved forward, R2 started to go down with the right side of the sling fell first. NA-C stated the lift loops were secure after repositioning R2's arm because R2 remained in an upright position.	21850		

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21850	Continued From page 6 On 11/7/17 at 3:10 p.m., NA-B stated that during the transfer activity, staff were talking about non-transfer related things. She witnessed staff adjusting R2's arm in the bathroom, right over the toilet. She did not see any loops loose at that time but could not verify if she looked at them during the entire transfer. NA-B remembers thinking the gap in the track at the bathroom door was big and had never seen a gap that big in a track before. NA-B believed the lift got hooked in between the gap at the bathroom door making the transfer difficult and does not remember seeing anyone checking the loops and hooks to be secure. Interview with Safety Coordinator (SC)-E team member on 11/9/17 at 1:05 p.m., SC-E verified that there were no mechanical or defective issues with the sling or lift; observed the sling was in good working order; no frays or cuts in the sling making it inappropriate to use. Interview with RN-D on 11/9/17 at 3:07 p.m., went to R2's room after hearing screams. RN-D saw R2 on the floor and 3 of the 4 loops were still attached to the lift. On 11/7/17 at 2:23 p.m., interview with FM-F stated that he was told the lift was in good working order and the fall had to be related to not being properly hooked up. He has observed staff transfer R2 before and feels they could have performed more supervision during the transfers. On 12/4/17 at 9:35 a.m., interview with FM-G indicated that full lift transfers were observed before and staff many times lifted R2 too high above the ground, lifting R2 as high as the lift would go. FM-G also observed staff being inattentive and conversing about non-transfer related things during transfers and had to remind	21850		

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21850	Continued From page 7 staff to pay attention to the transfer. In the policy titled Safe Lifting and Movement of Residents, dated 8/22/16 indicates, in order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Suggested Method of Correction: The administrator, director of nursing (DON), or designee could revise facility policies related to maltreatment. They could ensure all staff are aware of the importance of providing care for residents in accordance with facility policy and procedures, and could establish a system to audit. The administrator, director of nursing (DON), or designee could report that information gathered from audits to the quality assurance performance improvement (QAPI) committee, to ensure sustained correction and compliance. Time Period for Correction: Twenty-one (21) Days	21850		