MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Meeker Manor Rehab Center	H5361011	December 15, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
600 South Davis Avenue	8:00 a.m.- 4:45 p.m.	March 9, 2017
Facility City:	**Investigator's Name and Title:**	
Litchfield	Jessica Sellner, RN, Special Investigator	

State:	ZIP:	County:
Minnesota	55355	Meeker

☒ **Nursing Home**

Allegation(s):
It is alleged that neglect occurred when a resident received two fentanyl patches instead of one patch. The resident became unresponsive with hypotension needing immediate medical intervention.

- ☒ 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, neglect is substantiated. The facility failed to ensure staff were implementing the policy and procedure for administration and destruction of the resident's fentanyl patch. The resident became unresponsive and was sent to the hospital. The hospital determined the resident had two sets of fentanyl patches on.

The resident has severe cognitive impairment and requires staff assistance with all activities of daily living. The residents physician order directed staff to apply 37.5 mcg fentanyl patch every three days for pain. The order instructed licensed staff to remove the old fentanyl patch with a second nurse to co-sign and verify the removal.

One day, the resident was being assisted with cares by direct care staff, began to vomit, and became unresponsive. The resident stopped breathing and CPR was initiated by nursing. The resident began to respond, and was transported to the hospital by ambulance. After the resident was admitted to the hospital, hospital staff discovered the resident had two sets of fentanyl patches on. The hospital removed the fentanyl patches and the resident began to wake up and recover. The diagnoses for hospital admission included medication error with duplicate fentanyl patches present. The resident was admitted to the hospital overnight and returned to the facility the following day.

When interviewed, the nurse who applied the fentanyl patch prior to the resident being admitted to the hospital stated s/he thought the other set of fentanyl patches had been removed from the resident before

placing the new fentanyl patch. The nurse was aware of the facility policy that directed two staff to witness and sign off the disposal of the fentanyl patch after removal, however, the nurse stated there was no place to document the second nurses signature.

When staff were interviewed, they stated when removing any resident's fentanyl patch two nurses should be present and both nurses should document the destruction. However, staff stated the facility did not have a place for the second nurse to sign off they witnessed the destruction of the fentanyl patch.

Review of the residents medication administration record and the narcotic book included only one nurse's signature for the destruction and administration of the fentanyl patch.

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 their staff were following the facility policy and procedure for proper administration and destruction of an opioid medication. The facility failed to have a system set up for staff to properly follow their medication administration and destruction policy and procedure.

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:

Facility Corrective Action:

The facility took the following corrective action(s):

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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

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

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics

Additional facility records:

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

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Eight

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

Specify: _____

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

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with 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: Seven

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

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:

- [x] Personal Care
- [x] Nursing Services
- [x] Infection Control
- [x] Medication Pass
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] 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 - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Litchfield Police Department

Litchfield City Attorney

Meeker County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5361011. As a result, the following deficiencies are issued. 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 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication was administered according to facility policy and procedure to prevent significant medication error for 1 of 8 residents, R1, who received a Fentanyl patch for pain. This resulted in actual harm for R1 when the resident went unresponsive and was sent to the hospital. R1 was found to have two sets of Fentanyl patches on. Findings include: R1's admission Minimum Data Set dated 12/12/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's (activity's of daily living). R1's physician orders dated 11/29/16, directed Fentanyl Patch 37.5 mcg (micrograms) apply 12.5 mcg and 25 mcg patch to equal 37.5 mcg every 3 days for pain, "Remove old patch[s], 2nd nurse to co-sign and verify removal."	F 333		

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 333	Continued From page 1 R1's facility Admission/ Readmission Assessment Face Sheet dated 11/29/16, indicated the resident received Fentanyl Patch 37.5 mcg. R1's Progress note dated 11/30/16, indicated, "Apply 25 mcg transdermally [on the skin] at bedtime every 3 days for pain, Remove old patch, 2nd nurse to co-sign and verify removal. Placed last night to equal 37.5 mcg patch per [licensed practical nurse-H]." R1's Progress Note dated 12/3/16, indicated, At 8:00 p.m. resident stated to nurse that she had to use the bathroom for a BM [bowel movement]. "Writer took her and just before wanted to get her up she became very pale, tilted her head back and became unresponsive for a few seconds. When she came back she had a big emesis. She became unresponsive again and writer quickly checked code status which was a 'full code' CPR. When writer got back to her she was alert." "She vomited more and became unresponsive again. Writer with help of NA/R [nursing assistant] laid her on floor. All of a sudden res stopped breathing, became unresponsive, and no pulse (apical) Writer started CPR starting with chest compressions. Writer did approx [approximately] 6 compressions and res responded, woke up; did more vomiting." "Ambulance arrived at 2015 [8:15 p.m.] and took res to ER [emergency room]. When res left she was alert and pleasant." R1's hospital Progress Note- Final report dated 12/4/16, indicated, "After admission, staff found her current Fentanyl patches from 12/3/16, plus her old patches from 11/30/16 that had not been removed. They removed them. She has woken up and is doing much better." The assessment of the admission was, "Syncope multifactorial,	F 333		

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F 333	Continued From page 2	F 333		

combination of postoperative anemia, diarrhea, dehydration, and medication error with duplicate Fentanyl patches present."

R1's Patient Transfer Form, Medical Summary Completed by Physician dated 12/4/16, indicated the primary diagnosis for the hospital stay was sedation, medication error syncope, and multifactorial.

Review of R1's Medication Administration Record (MAR) for November 2016, directed, "Fentanyl Patch 72 hour 37.5 mcg/ hr apply 12.5 mcg transdermally at bedtime every 3 day(s) for pain *Remove old patch, 2nd nurse to co-sign and verify removal.*" R1 received the Fentanyl patches on 11/29/16, however, the MAR only had one nurses signature.

R1's MAR for December 2016, indicated the resident received Fentanyl Patches on 12/2/16. However, the MAR only had one nurses signature.

Review of R1's Narcotic Record indicated the resident received a 12.5 mcg and a 25 mcg patch on 11/29/16, and on 12/2/16. The Narcotic Record only had one nurses signature for both dates.

When interviewed on 12/15/16, at 9:00 a.m. licensed practical nurse (LPN)-C stated after removal of a Fentanyl patch it is wrapped in a tissue and flushed down the toilet. LPN-C stated after removing a patch another nurse is shown the patch but is not always present when flushing it down the toilet. LPN-C stated the second nurse does not sign witnessing the destruction because there is no where for two nurses to sign in the

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F 333	Continued From page 3 residents medical record. When interviewed on 12/15/16, at 9:45 a.m. LPN-D stated two nurses witness the destruction of the Fentanyl patches and both nurses should be signing on the residents MAR, however, there is not always a spot for both nurses to sign the destruction. When interviewed on 12/15/16, at 9:50 a.m. LPN-E stated two nurses witness the Fentanyl patch destruction, however, there is not always a spot for the second nurse to sign it was witnessed. LPN-E also stated the facility used an electronic MAR for all residents and depending on how the initial medication order was placed in the computer would determine if there was an area for a second nurse to sign for the destruction. When interviewed on 12/15/16, at 3:25 p.m. director of nursing (DON) stated staff were expected to have two nurses destroying the used Fentanyl patches and both should be signing off in the narcotic book. DON stated she had reviewed residents MAR's and narcotic records who had been on Fentanyl patches and discovered staff had not been obtaining two signatures when destroying them. When interviewed on 12/15/16, at 3:55 p.m. registered nurse (RN)-F stated she removed R1's Fentanyl patches on 12/2/16, and had another nurse witnessed the disposal. RN-F could not remember specifically who the other nurse was, and stated the other nurse did not sign off witnessing the destruction of the Fentanyl patches because there was no where for a second signature on the MAR verifying the	F 333		

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F 333	Continued From page 4 destruction. RN-F stated when she removed a Fentanyl Patch from any resident she puts them in a cup and destroyed them all at once at the end of the shift with another nurse. The facility policy titled Fentanyl Removal, Application and Destruction dated 10/2013, indicated, "Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction."	F 333		
F 431 SS=G	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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	F 431		

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F 431	Continued From page 5 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs 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 interview and record review, the facility failed to ensure policy and procedures for disposal of Fentanyl patches were followed for 8 of 8 residents, R1, R2, R3, R4, R5, R6, R7, and R8, reviewed who received a Fentanyl patch for pain. This resulted in actual harm for R1 when the resident went unresponsive and was sent to	F 431		

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F 431	Continued From page 6 the hospital. R1 was found to have two sets of Fentanyl patches on. Findings include: R1's admission Minimum Data Set dated 12/12/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's (activity's of daily living). R1's physician orders dated 11/29/16, directed Fentanyl Patch 37.5 mcg (micrograms) apply 12.5 mcg and 25 mcg patch to equal 37.5 mcg every 3 days for pain, "Remove old patch, 2nd nurse to co-sign and verify removal." R1's facility Admission/ Readmission Assessment Face Sheet dated 11/29/16, indicated the resident received Fentanyl Patch 37.5 mcg. Review of R1's Progress Notes indicated the following: R1's Progress Note dated 11/30/16, directed staff to apply 25 mcg transdermally [on the skin] at bedtime every 3 days for pain, Remove old patch, 2nd nurse to co-sign and verify removal. "Placed last night to equal 37.5 mcg patch per [licensed practical nurse-H]." R1's Progress Note dated 12/3/16, indicated at 8:00 p.m. R1 told the nurse she had to go to bathroom for a BM [bowel movement]. "Writer took her and just before wanted to get her up she became very pale, tilted her head back and became unresponsive for a few seconds. When she came back she had a big emesis. She became unresponsive again and writer quickly checked code status which was a 'full code' CPR.	F 431		

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F 431	Continued From page 7 When writer got back to her she was alert." "She vomited more and became unresponsive again. Writer with help of NA/R [nursing assistant] laid her on floor. All of a sudden res stopped breathing, became unresponsive, and no pulse (apical) Writer started CPR starting with chest compressions. Writer did approx [approximately] 6 compressions and res responded, woke up; did more vomiting." "Ambulance arrived at 2015 [8:15 p.m.] and took res to ER [emergency room]. When res left she was alert and pleasant." R1's hospital Progress Note- Final report dated 12/4/16, indicated, "After admission, staff found her current Fentanyl patches from 12/3/16, plus her old patches from 11/30/16 that had not been removed. They removed them. She has woken up and is doing much better." The assessment of the admission was, "Syncope multifactorial, combination of postoperative anemia, diarrhea, dehydration, and medication error with duplicate Fentanyl patches present." R1's Patient Transfer Form, Medical Summary Completed by Physician dated 12/4/16, indicated the primary diagnosis for the hospital stay was, "Sedation; med [medication] error syncope; multifactorial." Review of R1's Medication Administration Record (MAR) for November 2016, directed, "Fentanyl Patch 72 hour 37.5 mcg/ hr apply 12.5 mcg transdermally at bedtime every 3 day(s) for pain *Remove old patch, 2nd nurse to co-sign and verify removal.*" R1 received the Fentanyl patches on 11/29/16, however, the MAR only had one nurses signature. R1's MAR for December 2016, indicated the	F 431		

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F 431	Continued From page 8	F 431		

resident received Fentanyl Patches on 12/2/16. However, the MAR only had one nurses signature.

Review of R1's Narcotic Record indicated the resident received a 12.5 mcg and a 25 mcg patch on 11/29/16, and on 12/2/16. The Narcotic Record only had one nurses signature.

When interviewed on 12/15/16, at 3:55 p.m. registered nurse (RN)-F stated she removed R1's Fentanyl patches on 12/2/16, and had another nurse witness the destruction. RN-F could not remember specifically who the other nurse was, and stated the other nurse did not sign off witnessing the destruction of the Fentanyl patch's because there was no where for a second signature on the MAR verifying the destruction. RN-F stated when she removed a Fentanyl Patch from any resident she put them in a cup and destroyed them all at once at the end of the shift with another nurse.

R2's admission MDS dated 11/7/16, indicated the resident had no cognitive impairment and required limited assistance with ADL's.

R2's physician orders dated 12/15/16, directed Fentanyl patch 72 hour 25 mcg/ hr. Apply one patch transdermally every 72 hours for pain and remove per schedule.

R2's MAR for November 2016, indicated the Fentanyl patch was applied and removed 10 times. The MAR had only one nurse signature for all 10 Fentanyl patch disposals.

R2's December 2016, MAR was reviewed through December 15, 2016. R2 received a new

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Fentanyl patch four times. The MAR contained only one nurse signature for all four Fentanyl patch disposals.

R2's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic Record had only one nurses signature 13 out of 14 times.

R3's quarterly MDS dated 10/5/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's.

R3's physician orders dated 12/15/16, directed Fentanyl patch 72 hour 25 mcg/ hr apply one patch transdermally in the afternoon every 3 day(s) for pain. First nurse to remove, second nurse to co-sign.

R3's November 2016 MAR indicated the Fentanyl patch was applied and removed 10 times. The MAR had only one nurses signature six out of 10 times.

R3's December 2016 MAR was reviewed through December 15, 2016. R3 received the Fentanyl Patch five times. The MAR had a second nurses signature for all five disposals.

R3's Individual Narcotic record was reviewed from November 1, 2016, to December 15, 2016. The Narcotic record had only one nurses signature eight out of 15 times.

R4's quarterly MDS dated 12/22/16, indicated the resident had no cognitive impairment and was independent with all ADL's.

R4's physician orders dated 12/15/16, directed

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F 431	Continued From page 10 Fentanyl patch every 72 hour 12 mcg/ hr apply one patch transdermally every 72 hours for pain, change patch every 3 days, and remove per schedule. R4's November 2016, MAR indicated the resident received the Fentanyl patch 10 times. The MAR had only one nurses signature for all 10 disposals. R4's December 2016, MAR was reviewed through December 15, 2016. R4 received the Fentanyl patch four times. The MAR had only one nurse signature for all four disposals. R4's Individual Narcotic record was reviewed from November 1 2016, to December 15, 2016. The Narcotic record had only one nurses signature 11 out of 14 times. R5's quarterly MDS dated 11/3/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's. R5's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours, 25 mcg/ hr apply one patch transdermally every three days for pain. Remove old patch, second nurse to co-sign and verify removal. R5's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature six out of 10 times. R5's December 2016, MAR was reviewed through December 15, 2016. R5 received the Fentanyl patch four times. All four disposals were signed by a second nurse.	F 431		

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F 431	Continued From page 11 R5's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature 10 out of 14 times. R6's quarterly MDS dated 11/2/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's. R6's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 12 mcg/ hr. Apply one patch transdermally every 3 days for pain. Remove old patch, second nurse to co-sign and verify removal. R6's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature two out of 10 times. R6's December 2016 MAR was reviewed through December 15, 2016. R6 received the Fentanyl patch five times. All five were signed by two nurses. R6's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature nine out of 15 times. R7's quarterly MDS dated 11/10/16, indicated the resident had moderate cognitive impairment and required extensive assistance with all ADL's. R7's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 50 mcg/ hr. Apply one patch transdermally every 72 hours for pain. Remove old patch, second nurse to co-sign and verify removal.	F 431		

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F 431	Continued From page 12 R7's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature two out of 10 times. R7's December 2016 MAR was reviewed through December 15, 2016. R7 received the Fentanyl patch five times. All five were signed by two nurses. R7 Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature nine out of 15 times. R8's quarterly MDS dated 11/17/16, indicated the resident had no cognitive impairment and required extensive assistance with all ADL's. R8's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 25 mcg/ hr. Apply one patch transdermally every three days for pain. Remove old patch, second nurse to co-sign and verify removal. R8's November 2016, MAR indicated the resident received Fentanyl patch eight times. The MAR had only one nurses signature five out of eight times. R8's December 2016 MAR was reviewed through December 15, 2016. R8 received the Fentanyl patch five times. All five were signed by two nurses. R8 Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurse signature eight out of 13 times.	F 431		

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F 431	Continued From page 13 When interviewed on 12/15/16, at 9:00 a.m. licensed practical nurse (LPN)-C stated after removal of a Fentanyl patch it is wrapped in a tissue and flushed down the toilet. LPN-C stated after removing a patch another nurse is shown the patch but is not always present when flushing it down the toilet. LPN-C stated the second nurse does not sign witnessing the destruction because there is no where for two nurses to sign in the residents medical record. When interviewed on 12/15/16, at 9:45 a.m. LPN-D stated two nurses witness the destruction of the Fentanyl patches and both nurses should be signing on the residents MAR, however, there is not always a spot for both nurses to sign the destruction. When interviewed on 12/15/16, at 9:50 a.m. LPN-E stated two nurses witness the Fentanyl patch destruction, however, there is not always a spot for the second nurse to sign it was witnessed. LPN-E also stated the facility used an electronic MAR for all residents and depending on how the initial medication order was placed in the computer would determine if there was an area for a second nurse to sign for the destruction. When interviewed on 12/15/16, at 3:25 p.m. director of nursing (DON) stated staff were expected to have two nurses destroying the used Fentanyl patches and both should be signing off in the narcotic book. DON stated she had reviewed residents MAR's and narcotic records who had been on Fentanyl patches and discovered staff had not been obtaining two signatures when destroying them.	F 431		

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F 431	Continued From page 14 The facility policy titled Fentanyl Removal, Application and Destruction dated 10/2013, indicated, "Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction."	F 431		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5361011. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		

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21545	Continued From page 2 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication was administered according to facility policy and procedure to prevent significant medication error for 1 of 8 residents, R1, who received a Fentanyl patch for pain. This resulted in actual harm for R1 when the resident went unresponsive and was sent to the hospital. R1 was found to have two sets of Fentanyl patches on. Findings include: R1's admission Minimum Data Set dated 12/12/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's (activity's of daily living).	21545		

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21545	Continued From page 3 R1's physician orders dated 11/29/16, directed Fentanyl Patch 37.5 mcg (micrograms) apply 12.5 mcg and 25 mcg patch to equal 37.5 mcg every 3 days for pain, "Remove old patch[s], 2nd nurse to co-sign and verify removal." R1's facility Admission/ Readmission Assessment Face Sheet dated 11/29/16, indicated the resident received Fentanyl Patch 37.5 mcg. R1's Progress note dated 11/30/16, indicated, "Apply 25 mcg transdermally [on the skin] at bedtime every 3 days for pain, Remove old patch, 2nd nurse to co-sign and verify removal. Placed last night to equal 37.5 mcg patch per [licensed practical nurse-H]." R1's Progress Note dated 12/3/16, indicated, At 8:00 p.m. resident stated to nurse that she had to use the bathroom for a BM [bowel movement]. "Writer took her and just before wanted to get her up she became very pale, tilted her head back and became unresponsive for a few seconds. When she came back she had a big emesis. She became unresponsive again and writer quickly checked code status which was a 'full code' CPR. When writer got back to her she was alert." "She vomited more and became unresponsive again. Writer with help of NA/R [nursing assistant] laid her on floor. All of a sudden res stopped breathing, became unresponsive, and no pulse (apical) Writer started CPR starting with chest compressions. Writer did approx [approximately] 6 compressions and res responded, woke up; did more vomiting." "Ambulance arrived at 2015 [8:15 p.m.] and took res to ER [emergency room]. When res left she was alert and pleasant." R1's hospital Progress Note- Final report dated 12/4/16, indicated, "After admission, staff found	21545		

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21545	Continued From page 4 her current Fentanyl patches from 12/3/16, plus her old patches from 11/30/16 that had not been removed. They removed them. She has woken up and is doing much better." The assessment of the admission was, "Syncope multifactorial, combination of postoperative anemia, diarrhea, dehydration, and medication error with duplicate Fentanyl patches present." R1's Patient Transfer Form, Medical Summary Completed by Physician dated 12/4/16, indicated the primary diagnosis for the hospital stay was sedation, medication error syncope, and multifactorial. Review of R1's Medication Administration Record (MAR) for November 2016, directed, "Fentanyl Patch 72 hour 37.5 mcg/ hr apply 12.5 mcg transdermally at bedtime every 3 day(s) for pain *Remove old patch, 2nd nurse to co-sign and verify removal.*" R1 received the Fentanyl patches on 11/29/16, however, the MAR only had one nurses signature. R1's MAR for December 2016, indicated the resident received Fentanyl Patches on 12/2/16. However, the MAR only had one nurses signature. Review of R1's Narcotic Record indicated the resident received a 12.5 mcg and a 25 mcg patch on 11/29/16, and on 12/2/16. The Narcotic Record only had one nurses signature for both dates. When interviewed on 12/15/16, at 9:00 a.m. licensed practical nurse (LPN)-C stated after removal of a Fentanyl patch it is wrapped in a tissue and flushed down the toilet. LPN-C stated after removing a patch another nurse is shown	21545		

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21545	Continued From page 5	21545		

the patch but is not always present when flushing it down the toilet. LPN-C stated the second nurse does not sign witnessing the destruction because there is no where for two nurses to sign in the residents medical record.

When interviewed on 12/15/16, at 9:45 a.m. LPN-D stated two nurses witness the destruction of the Fentanyl patches and both nurses should be signing on the residents MAR, however, there is not always a spot for both nurses to sign the destruction.

When interviewed on 12/15/16, at 9:50 a.m. LPN-E stated two nurses witness the Fentanyl patch destruction, however, there is not always a spot for the second nurse to sign it was witnessed. LPN-E also stated the facility used an electronic MAR for all residents and depending on how the initial medication order was placed in the computer would determine if there was an area for a second nurse to sign for the destruction.

When interviewed on 12/15/16, at 3:25 p.m. director of nursing (DON) stated staff were expected to have two nurses destroying the used Fentanyl patches and both should be signing off in the narcotic book. DON stated she had reviewed residents MAR's and narcotic records who had been on Fentanyl patches and discovered staff had not been obtaining two signatures when destroying them.

When interviewed on 12/15/16, at 3:55 p.m. registered nurse (RN)-F stated she removed R1's Fentanyl patches on 12/2/16, and had another nurse witnessed the disposal. RN-F could not remember specifically who the other nurse was, and stated the other nurse did not sign off

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21545	Continued From page 6 witnessing the destruction of the Fentanyl patches because there was no where for a second signature on the MAR verifying the destruction. RN-F stated when she removed a Fentanyl Patch from any resident she puts them in a cup and destroyed them all at once at the end of the shift with another nurse. The facility policy titled Fentanyl Removal, Application and Destruction dated 10/2013, indicated, "Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction." SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff, and implement an ongoing monitoring system to ensure all staff are following policy and procedures when administering and disposing Fentanyl Patches. TIME PERIOD FOR CORRECTION: Ten (10) days.	21545		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or	21630		

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21630	Continued From page 7 discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure policy and procedures for disposal of Fentanyl patches were followed for 8 of 8 residents, R1, R2, R3, R4, R5, R6, R7, and R8, reviewed who received a Fentanyl patch for pain. This resulted in actual harm for R1 when the resident went unresponsive and was sent to the hospital. R1 was found to have two sets of Fentanyl patches on. Findings include: R1's admission Minimum Data Set dated 12/12/16, indicated the resident had severe cognitive impairment and required extensive	21630		

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21630	Continued From page 8 assistance with all ADL's (activity's of daily living). R1's physician orders dated 11/29/16, directed Fentanyl Patch 37.5 mcg (micrograms) apply 12.5 mcg and 25 mcg patch to equal 37.5 mcg every 3 days for pain, "Remove old patch, 2nd nurse to co-sign and verify removal." R1's facility Admission/ Readmission Assessment Face Sheet dated 11/29/16, indicated the resident received Fentanyl Patch 37.5 mcg. Review of R1's Progress Notes indicated the following: R1's Progress Note dated 11/30/16, directed staff to apply 25 mcg transdermally [on the skin] at bedtime every 3 days for pain, Remove old patch, 2nd nurse to co-sign and verify removal. "Placed last night to equal 37.5 mcg patch per [licensed practical nurse-H]." R1's Progress Note dated 12/3/16, indicated at 8:00 p.m. R1 told the nurse she had to go to bathroom for a BM [bowel movement]. "Writer took her and just before wanted to get her up she became very pale, tilted her head back and became unresponsive for a few seconds. When she came back she had a big emesis. She became unresponsive again and writer quickly checked code status which was a 'full code' CPR. When writer got back to her she was alert." "She vomited more and became unresponsive again. Writer with help of NA/R [nursing assistant] laid her on floor. All of a sudden res stopped breathing, became unresponsive, and no pulse (apical) Writer started CPR starting with chest compressions. Writer did approx [approximately] 6 compressions and res responded, woke up; did more vomiting." "Ambulance arrived at 2015	21630		

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21630	Continued From page 9 [8:15 p.m.] and took res to ER [emergency room]. When res left she was alert and pleasant." R1's hospital Progress Note- Final report dated 12/4/16, indicated, "After admission, staff found her current Fentanyl patches from 12/3/16, plus her old patches from 11/30/16 that had not been removed. They removed them. She has woken up and is doing much better." The assessment of the admission was, "Syncope multifactorial, combination of postoperative anemia, diarrhea, dehydration, and medication error with duplicate Fentanyl patches present." R1's Patient Transfer Form, Medical Summary Completed by Physician dated 12/4/16, indicated the primary diagnosis for the hospital stay was, "Sedation; med [medication] error syncope; multifactorial." Review of R1's Medication Administration Record (MAR) for November 2016, directed, "Fentanyl Patch 72 hour 37.5 mcg/ hr apply 12.5 mcg transdermally at bedtime every 3 day(s) for pain *Remove old patch, 2nd nurse to co-sign and verify removal.*" R1 received the Fentanyl patches on 11/29/16, however, the MAR only had one nurses signature. R1's MAR for December 2016, indicated the resident received Fentanyl Patches on 12/2/16. However, the MAR only had one nurses signature. Review of R1's Narcotic Record indicated the resident received a 12.5 mcg and a 25 mcg patch on 11/29/16, and on 12/2/16. The Narcotic Record only had one nurses signature. When interviewed on 12/15/16, at 3:55 p.m.	21630		

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21630	Continued From page 10 registered nurse (RN)-F stated she removed R1's Fentanyl patches on 12/2/16, and had another nurse witness the destruction. RN-F could not remember specifically who the other nurse was, and stated the other nurse did not sign off witnessing the destruction of the Fentanyl patch's because there was no where for a second signature on the MAR verifying the destruction. RN-F stated when she removed a Fentanyl Patch from any resident she put them in a cup and destroyed them all at once at the end of the shift with another nurse. R2's admission MDS dated 11/7/16, indicated the resident had no cognitive impairment and required limited assistance with ADL's. R2's physician orders dated 12/15/16, directed Fentanyl patch 72 hour 25 mcg/ hr. Apply one patch transdermally every 72 hours for pain and remove per schedule. R2's MAR for November 2016, indicated the Fentanyl patch was applied and removed 10 times. The MAR had only one nurse signature for all 10 Fentanyl patch disposals. R2's December 2016, MAR was reviewed through December 15, 2016. R2 received a new Fentanyl patch four times. The MAR contained only one nurse signature for all four Fentanyl patch disposals. R2's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic Record had only one nurses signature 13 out of 14 times. R3's quarterly MDS dated 10/5/16, indicated the resident had severe cognitive impairment and	21630		

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21630	Continued From page 11 required extensive assistance with all ADL's. R3's physician orders dated 12/15/16, directed Fentanyl patch 72 hour 25 mcg/ hr apply one patch transdermally in the afternoon every 3 day(s) for pain. First nurse to remove, second nurse to co-sign. R3's November 2016 MAR indicated the Fentanyl patch was applied and removed 10 times. The MAR had only one nurses signature six out of 10 times. R3's December 2016 MAR was reviewed through December 15, 2016. R3 received the Fentanyl Patch five times. The MAR had a second nurses signature for all five disposals. R3's Individual Narcotic record was reviewed from November 1, 2016, to December 15, 2016. The Narcotic record had only one nurses signature eight out of 15 times. R4's quarterly MDS dated 12/22/16, indicated the resident had no cognitive impairment and was independent with all ADL's. R4's physician orders dated 12/15/16, directed Fentanyl patch every 72 hour 12 mcg/ hr apply one patch transdermally every 72 hours for pain, change patch every 3 days, and remove per schedule. R4's November 2016, MAR indicated the resident received the Fentanyl patch 10 times. The MAR had only one nurses signature for all 10 disposals. R4's December 2016, MAR was reviewed through December 15, 2016. R4 received the	21630		

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21630	Continued From page 12 Fentanyl patch four times. The MAR had only one nurse signature for all four disposals. R4's Individual Narcotic record was reviewed from November 1 2016, to December 15, 2016. The Narcotic record had only one nurses signature 11 out of 14 times. R5's quarterly MDS dated 11/3/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's. R5's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours, 25 mcg/ hr apply one patch transdermally every three days for pain. Remove old patch, second nurse to co-sign and verify removal. R5's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature six out of 10 times. R5's December 2016, MAR was reviewed through December 15, 2016. R5 received the Fentanyl patch four times. All four disposals were signed by a second nurse. R5's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature 10 out of 14 times. R6's quarterly MDS dated 11/2/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's. R6's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 12 mcg/ hr. Apply one patch transdermally every 3 days for pain. Remove old patch, second nurse to co-sign and	21630		

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21630	Continued From page 13 verify removal. R6's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature two out of 10 times. R6's December 2016 MAR was reviewed through December 15, 2016. R6 received the Fentanyl patch five times. All five were signed by two nurses. R6's Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature nine out of 15 times. R7's quarterly MDS dated 11/10/16, indicated the resident had moderate cognitive impairment and required extensive assistance with all ADL's. R7's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 50 mcg/ hr. Apply one patch transdermally every 72 hours for pain. Remove old patch, second nurse to co-sign and verify removal. R7's November 2016, MAR indicated the resident received Fentanyl patch 10 times. The MAR had only one nurses signature two out of 10 times. R7's December 2016 MAR was reviewed through December 15, 2016. R7 received the Fentanyl patch five times. All five were signed by two nurses. R7 Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurses signature nine out of 15 times.	21630		

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21630	Continued From page 14 R8's quarterly MDS dated 11/17/16, indicated the resident had no cognitive impairment and required extensive assistance with all ADL's. R8's physician orders dated 12/15/16, directed Fentanyl patch every 72 hours 25 mcg/ hr. Apply one patch transdermally every three days for pain. Remove old patch, second nurse to co-sign and verify removal. R8's November 2016, MAR indicated the resident received Fentanyl patch eight times. The MAR had only one nurses signature five out of eight times. R8's December 2016 MAR was reviewed through December 15, 2016. R8 received the Fentanyl patch five times. All five were signed by two nurses. R8 Individual Narcotic Record was reviewed from November 1, 2016 to December 15, 2016. The Narcotic record had only one nurse signature eight out of 13 times. When interviewed on 12/15/16, at 9:00 a.m. licensed practical nurse (LPN)-C stated after removal of a Fentanyl patch it is wrapped in a tissue and flushed down the toilet. LPN-C stated after removing a patch another nurse is shown the patch but is not always present when flushing it down the toilet. LPN-C stated the second nurse does not sign witnessing the destruction because there is no where for two nurses to sign in the residents medical record. When interviewed on 12/15/16, at 9:45 a.m. LPN-D stated two nurses witness the destruction of the Fentanyl patches and both nurses should be signing on the residents MAR, however, there	21630		

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21630	Continued From page 15 is not always a spot for both nurses to sign the destruction. When interviewed on 12/15/16, at 9:50 a.m. LPN-E stated two nurses witness the Fentanyl patch destruction, however, there is not always a spot for the second nurse to sign it was witnessed. LPN-E also stated the facility used an electronic MAR for all residents and depending on how the initial medication order was placed in the computer would determine if there was an area for a second nurse to sign for the destruction. When interviewed on 12/15/16, at 3:25 p.m. director of nursing (DON) stated staff were expected to have two nurses destroying the used Fentanyl patches and both should be signing off in the narcotic book. DON stated she had reviewed residents MAR's and narcotic records who had been on Fentanyl patches and discovered staff had not been obtaining two signatures when destroying them. The facility policy titled Fentanyl Removal, Application and Destruction dated 10/2013, indicated, "Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction." SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff and implement an	21630		

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21630	Continued From page 16 ongoing monitoring system to ensure all staff are following facility policy's and procedures for disposal of Fentanyl patch. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
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 interview and record review, the facility failed to ensure 1 of 8 residents, R1, was free from maltreatment when a Fentanyl patch was not administered and/ or destroyed according to facility policy and procedure. This resulted in actual harm for R1 when the resident became unresponsive and was sent to the hospital. R1 was found to have two sets of Fentanyl patches on.	21850		

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21850	Continued From page 17 Findings include: R1's admission Minimum Data Set dated 12/12/16, indicated the resident had severe cognitive impairment and required extensive assistance with all ADL's (activity's of daily living). R1's physician orders dated 11/29/16, directed Fentanyl Patch 37.5 mcg (micrograms) apply 12.5 mcg and 25 mcg patch to equal 37.5 mcg every 3 days for pain, "Remove old patch[s], 2nd nurse to co-sign and verify removal." R1's facility Admission/ Readmission Assessment Face Sheet dated 11/29/16, indicated the resident received Fentanyl Patch 37.5 mcg. R1's Progress note dated 11/30/16, indicated, "Apply 25 mcg transdermally [on the skin] at bedtime every 3 days for pain, Remove old patch, 2nd nurse to co-sign and verify removal. Placed last night to equal 37.5 mcg patch per [licensed practical nurse-H]." R1's Progress Note dated 12/3/16, indicated, At 8:00 p.m. resident stated to nurse that she had to use the bathroom for a BM [bowel movement]. "Writer took her and just before wanted to get her up she became very pale, tilted her head back and became unresponsive for a few seconds. When she came back she had a big emesis. She became unresponsive again and writer quickly checked code status which was a 'full code' CPR. When writer got back to her she was alert." "She vomited more and became unresponsive again. Writer with help of NA/R [nursing assistant] laid her on floor. All of a sudden res stopped breathing, became unresponsive, and no pulse (apical) Writer started CPR starting with chest	21850		

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21850	Continued From page 18 compressions. Writer did approx [approximately] 6 compressions and res responded, woke up; did more vomiting." "Ambulance arrived at 2015 [8:15 p.m.] and took res to ER [emergency room]. When res left she was alert and pleasant." R1's hospital Progress Note- Final report dated 12/4/16, indicated, "After admission, staff found her current Fentanyl patches from 12/3/16, plus her old patches from 11/30/16 that had not been removed. They removed them. She has woken up and is doing much better." The assessment of the admission was, "Syncope multifactorial, combination of postoperative anemia, diarrhea, dehydration, and medication error with duplicate Fentanyl patches present." R1's Patient Transfer Form, Medical Summary Completed by Physician dated 12/4/16, indicated the primary diagnosis for the hospital stay was sedation, medication error syncope, and multifactorial. Review of R1's Medication Administration Record (MAR) for November 2016, directed, "Fentanyl Patch 72 hour 37.5 mcg/ hr apply 12.5 mcg transdermally at bedtime every 3 day(s) for pain *Remove old patch, 2nd nurse to co-sign and verify removal.*" R1 received the Fentanyl patches on 11/29/16, however, the MAR only had one nurses signature. R1's MAR for December 2016, indicated the resident received Fentanyl Patches on 12/2/16. However, the MAR only had one nurses signature. Review of R1's Narcotic Record indicated the resident received a 12.5 mcg and a 25 mcg patch on 11/29/16, and on 12/2/16. The Narcotic	21850		

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21850	Continued From page 19 Record only had one nurses signature for both dates. When interviewed on 12/15/16, at 9:00 a.m. licensed practical nurse (LPN)-C stated after removal of a Fentanyl patch it is wrapped in a tissue and flushed down the toilet. LPN-C stated after removing a patch another nurse is shown the patch but is not always present when flushing it down the toilet. LPN-C stated the second nurse does not sign witnessing the destruction because there is no where for two nurses to sign in the residents medical record. When interviewed on 12/15/16, at 9:45 a.m. LPN-D stated two nurses witness the destruction of the Fentanyl patches and both nurses should be signing on the residents MAR, however, there is not always a spot for both nurses to sign the destruction. When interviewed on 12/15/16, at 9:50 a.m. LPN-E stated two nurses witness the Fentanyl patch destruction, however, there is not always a spot for the second nurse to sign it was witnessed. LPN-E also stated the facility used an electronic MAR for all residents and depending on how the initial medication order was placed in the computer would determine if there was an area for a second nurse to sign for the destruction. When interviewed on 12/15/16, at 3:25 p.m. director of nursing (DON) stated staff were expected to have two nurses destroying the used Fentanyl patches and both should be signing off in the narcotic book. DON stated she had reviewed residents MAR's and narcotic records who had been on Fentanyl patches and discovered staff had not been obtaining two	21850		

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21850	Continued From page 20 signatures when destroying them. When interviewed on 12/15/16, at 3:55 p.m. registered nurse (RN)-F stated she removed R1's Fentanyl patches on 12/2/16, and had another nurse witnessed the disposal. RN-F could not remember specifically who the other nurse was, and stated the other nurse did not sign off witnessing the destruction of the Fentanyl patches because there was no where for a second signature on the MAR verifying the destruction. RN-F stated when she removed a Fentanyl Patch from any resident she puts them in a cup and destroyed them all at once at the end of the shift with another nurse. The facility policy titled Fentanyl Removal, Application and Destruction dated 10/2013, indicated, "Take the used patch to the locked medication room (without touching adhesive sides), complete Fentanyl destruction log or Medication Disposal Form, with two licensed nurses wrapping used fentanyl patch in toilet paper and flushing down the sewer. Two licensed nurses must verify destruction and sign the proper form for proof of destruction." SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff, and implement an ongoing monitoring system to ensure all staff are following policy and procedures when administering and disposing Fentanyl Patches. TIME PERIOD FOR CORRECTION: Ten (10) days.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: _____ B. WING _____	C 01/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, I	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 17, 2017

Mr. Daniel Strittmater, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: Enclosed Reinspection Results - Complaint Number H5361011

Dear Mr. Strittmater:

On March 6, 2017 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 January 24, 2017. 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 17, 2017

Mr. Daniel Strittmater, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number H5361011

Dear Mr. Strittmater:

On February 1, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 6, 2017. (42 CFR 488.422)

On February 1, 2017, this Department recommended the following enforcement remedy to the Centers for Medicare and Medicaid Services (CMS) for imposition:

- Civil money penalty for the deficiency cited at F333. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F431. (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 January 24, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 6, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on January 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 10, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on January 24, 2017, as of February 28, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 28, 2017.

The CMS Region V Office will notify you of their determination regarding the recommended remedies,

- Civil money penalty for the deficiency cited at F333. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F431. (42 CFR 488.430 through 488.444)

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
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Enclosure(s)
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