MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Lake Shore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093
Waseca County

Report#: H5388006 and H5388007

Date: August 1, 2016

Date of Visit: February 12-13, 2016
Time of Visit: 8:00 a.m.-5:00 a.m.
7:30 a.m.-1:00 p.m.

By: Jane Aandal, RN, Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a resident was financially exploited when a staff, alleged perpetrator took resident's narcotics.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☐ Neglect ☑ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence financial exploitation did occur when the alleged perpetrator (AP) took approximately four tablets of oxycodone daily from two residents over approximately 8-10 days.

One resident was alert and oriented diagnosed with a total right hip replacement. The resident's physician had ordered Oxycodone HCl (used to treat acute pain) 5 milligrams (mg) every 4 hours as needed for pain (PRN).

The second resident was diagnosed with a fractured right femur. The resident's physician had ordered Oxycodone HCl 5 milligrams (mg) every 4 hours as needed for pain

On an evening shift a nurse went to administer Oxycodone HCL 5 mg PRN to the second resident who had requested pain medication. The nurse noted the Oxycodone package had been tampered with and medication was taped in the package. The nurse called and informed administration. The nurse noticed the medications that were taped into the package were different. Administration instructed the nurse to lock up the tampered packages of Oxycodone in the office.

The consulting pharmacist was notified and verified the Oxycodone tablets had been replaced with seventeen other medications for the first resident and sixteen other medications for the second resident. The police were notified of the incident.

The police report indicated the AP confessed to taking the Oxycodone from the two residents. The AP stated s/he had been taking the Oxycodone from the two residents for the past 8-10 days. The AP stated s/he had been taking on average four tablets each day when s/he worked. The AP stated on the evening of the incident s/he thought s/he took seven tablets and consumed them. The AP admitted to replacing the Oxycodone with other medications.

The AP was interviewed and stated that 8-10 days prior to the incident s/he had taken approximately 40 tablets of Oxycodone 5 mg from the two residents on Oxycodone. The AP stated s/he took the medications for his/her own personal use. The AP stated s/he replaced the Oxycodone with other medications and taped them into the package. The AP stated s/he was charged with third degree narcotic possession.

There was no evidence the resident's suffered ill effects as a result of the incident.

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 policies in place to secure controlled medications and related to financial exploitation. The nurse was trained on the policies and procedures.

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 If no, specify: _____

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

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

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 If no, specify: _____

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

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation
"Financial exploitation" means:

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

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

The Investigation included the following:

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

☒ Medical Records
☐ Care Guide
☒ Medication Administration Records
☐ Treatment Sheets
☐ Facility Incident Reports
☐ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets
☐ Laboratory and X-ray Reports
☒ Physician Orders
☐ Social Service Notes

☐ Nurses Notes ☐ Meal Intake Records

☐ Activities Reports ☐ Weight Records

☐ Therapy and/or Ancillary Services Records ☐ Assessments

☐ Skin Assessments ☐ Care Plan Records

☐ Service Plan ☐ Other, specify: _____

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☒ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes ☒ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☐ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 3

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: Facility Report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

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

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Unable to hear on the phone

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 7

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:

☐ Wound Care	☒ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☒ Other: Narcotic Counts

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A Specify: _____

Were photographs taken: ◉ Yes ○ No Specify: Medication Cart and tampered medication packages

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Minnesota Board of Pharmacy
The Office of Ombudsman for Long-Term Care
Waseca City Police Department
Waseca County Attorney
Waseca City Attorney

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LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5388006 & H5388007. As a result, the following deficiencies are issued related to #H5388006 & #H5388007. 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of financial exploitation was immediately reported to the State agency (SA) and provide evidence of a thorough investigation of potential drug diversion for 1 of 5 incidents reviewed affecting 2 of 2 residents (R1, R2) whose medications were missing. Findings include: R1's medical record was reviewed. R1 was diagnosed with status post right total hip replacement and had a physician's order dated 12/14/15, for Oxycodone HCL (used to treat acute pain) 5 milligrams (mg) every 4 hours as needed for pain. R2's medical record was reviewed. R2 was diagnosed with a fractured right femur and had a physician's order dated 10/26/15, for Oxycodone HCL 5 mg every 4 hours as needed for pain. An interview was conducted with licensed practical nurse (LPN)-C on 2/12/16, at 9:03 a.m. LPN-C stated registered nurse (RN)-F had called her at home between 10:30 a.m. and 11:00 a.m.	F 225		

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F 225	Continued From page 2 on 12/29/15. RN-F asked LPN-C if she should work for her due to weather conditions. LPN-C declined the offer. RN-F then stated last evening when she worked she had passed out and her arm fell into the narcotic box. LPN-C stated she did not think much about the comment. LPN-C stated she went into work on 12/29/15, at 2:30 p.m. and at 7:00 p.m. nursing assistant (NA)-E stated R2 wanted a pain pill for back pain. LPN-C stated when she took R2's Oxycodone card from the narcotic box, she noticed a lot of tape on the back of both Oxycodone packages. LPN-C stated this seemed odd and she was really alarmed by it. LPN-C stated she did not use a pill that was taped into the package and jokingly said to NA-E, what happened with RN-F last evening? NA-F explained that RN-F had hollered his name and he stated RN-F had her hand in the narcotic drawer. LPN-C stated between 9:00 p.m. and 9:30 p.m. on 12/29/15, she spoke with trained medication aide (TMA)-D and asked her what had happened last evening with RN-F. TMA explained that NA-E had requested she come to the South wing and she found RN-F seated in a chair. RN-F requested TMA-D check her blood sugar and blood pressure. RN-F told TMA-D there were a bunch of pills lying loose in the bottom of the narcotic drawer. TMA-D explained that RN-F instructed her to tape the pills back into the Oxycodone packages. LPN-C stated she could not believe it. LPN-C stated at about 10:30 p.m. she looked at the Oxycodone packages and noticed the pills were of different sizes and had different markings. LPN-C stated she then called the director of nursing (DON). LPN-C stated the DON instructed her to put the tampered packages of R1's Oxycodone (2 cards) and R2's Oxycodone (2 cards) in the DON's office and write up a statement. LPN-C stated TMA-D also	F 225		

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F 225	Continued From page 3 wrote up a statement for the DON. According to the facility's internal investigation on 12/30/15, the consulting pharmacist (CP)-G and the police were notified of the incident. CP-G examined R1's and R2's medications and confirmed numerous medications had been replaced with other medications which included Metoprolol (a blood pressure medication). The allegation of financial exploitation was not reported to the SA until 1/4/16, (6 days later) according to the investigative report submitted to the SA. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated R1 and R2 had medicare as their payor source at the time of the incident. The administrator stated the facility had purchased their medications and therefore had not viewed the incident as financial exploitation. The administrator stated the day they received direction from their provider group they reported the incident to the SA on 1/4/16. An interview was conducted with DON-A on 2/10/16, at 9:57 a.m. DON-A stated according to their policy they have 24 hours to report to the SA. DON-A verified the SA was not notified timely. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated the policy was vague regarding a thorough investigation. However, the administrator stated they have staff sign and date their statements. The facility's undated Procedures for Reporting Suspected Maltreatment indicated the possible maltreatment	F 225		

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F 225	Continued From page 4 would be thoroughly investigated. In addition, the administrator stated he was called by the DON on 12/29/15, after she was notified of the incident. An interview was conducted with DON-B on 2/11/16, at 11:30 a.m. DON-B stated RN-F worked on 12/27/15. RN-F had filled out a Dropped Dosage Form for a resident who was on Metoprolol and requested three tablets from the pharmacy. DON-B stated this information was lacking from the investigation. An interview was conducted with DON-B on 2/11/16, at 12:42 p.m. DON-B stated on 12/29/15, LPN-C checked both of the medication carts for any tampering of other medications. In addition, DON-B stated R1 and R2 were interviewed regarding their pain levels and DON-B verified this information was lacking from the investigation. The facility's undated Procedures for Reporting Suspected Maltreatment indicated if it is determined maltreatment may have occurred, the administrator or his/her delegate will submit a report to the Office of Health Facility Complaints (OHFC) on their electronic form. Both of these reports would be submitted within 24 hours of the initial report. Lakeshore Inn will thoroughly investigate the possible maltreatment.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop their vulnerable adult prevention policy to include immediately reporting to the State agency (SA) all allegations of mistreatment including financial exploitation and provide evidence of a thorough investigation of potential drug diversion for 1 of 5 incidents reviewed affecting residents (R1, R2) whose medications were missing. Findings include: The facility's undated Abuse Investigation Protocol indicated Minnesota's Vulnerable Adult Act (VAA) requires mandated reporters (including staff of skilled nursing facilities) to immediately report suspected maltreatment against vulnerable adults which includes incidents of abuse, neglect, or financial exploitation. The facility's undated Procedures for Reporting Suspected Maltreatment indicated if it is determined maltreatment may have occurred, the administrator or his/her delegate will submit a report to the Office of Health Facility Complaints (OHFC) on their electronic form. Both of these reports would be submitted within 24 hours of the initial report. Lakeshore Inn will thoroughly investigate the possible maltreatment. R1's medical record was reviewed. R1 was diagnosed with status post right total hip replacement and had a physician's order dated 12/14/15, for Oxycodone HCL (used to treat acute pain) 5 milligrams (mg) every 4 hours as needed	F 226		

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F 226	Continued From page 6 for pain. R2's medical record was reviewed. R2 was diagnosed with a fractured right femur and had a physician's order dated 10/26/15, for Oxycodone HCL 5 mg every 4 hours as needed for pain. An interview was conducted with licensed practical nurse (LPN)-C on 2/12/16, at 9:03 a.m. LPN-C stated registered nurse (RN)-F had called her at home between 10:30 a.m. and 11:00 a.m. on 12/29/15. RN-F asked LPN-C if she should work for her due to weather conditions. LPN-C declined the offer. RN-F then stated last evening when she worked she had passed out and her arm fell into the narcotic box. LPN-C stated she did not think much about the comment. LPN-C stated she went into work on 12/29/15, at 2:30 p.m. and at 7:00 p.m. nursing assistant (NA)-E stated R2 wanted a pain pill for back pain. LPN-C stated when she took R2's Oxycodone card from the narcotic box, she noticed a lot of tape on the back of both Oxycodone packages. LPN-C stated this seemed odd and she was really alarmed by it. LPN-C stated she did not use a pill that was taped into the package and jokingly said to NA-E, what happened with RN-F last evening? NA-F explained that RN-F had hollered his name and he stated RN-F had her hand in the narcotic drawer. LPN-C stated between 9:00 p.m. and 9:30 p.m. on 12/29/15, she spoke with trained medication aide (TMA)-D and asked her what had happened last evening with RN-F. TMA explained that NA-E had requested she come to the South wing and she found RN-F seated in a chair. RN-F requested TMA-D check her blood sugar and blood pressure. RN-F told TMA-D there were a bunch of pills lying loose in the bottom of the narcotic drawer. TMA-D explained	F 226		

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F 226	Continued From page 7 that RN-F instructed her to tape the pills back into the Oxycodone packages. LPN-C stated she could not believe it. LPN-C stated at about 10:30 p.m. she looked at the Oxycodone packages and noticed the pills were of different sizes and had different markings. LPN-C stated she then called the director of nursing (DON). LPN-C stated the DON instructed her to put the tampered packages of R1's Oxycodone (2 cards) and R2's Oxycodone (2 cards) in the DON's office and write up a statement. LPN-C stated TMA-D also wrote up a statement for the DON. According to the facility's internal investigation on 12/30/15, the consulting pharmacist (CP)-G and the police were notified of the incident. CP-G examined R1's and R2's medications and confirmed numerous medications had been replaced with other medications which included Metoprolol (a blood pressure medication). The allegation of financial exploitation was not reported to the SA until 1/4/16, (6 days later) according to the investigative report submitted to the SA. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated R1 and R2 had medicare as their payor source at the time of the incident. The administrator stated the facility had purchased their medications and therefore had not viewed the incident as financial exploitation. The administrator stated the day they received direction from their provider group they reported the incident to the SA on 1/4/16. An interview was conducted with DON-A on 2/10/16, at 9:57 a.m. DON-A stated according to their policy they have 24 hours to report to the	F 226		

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(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 226	Continued From page 8 SA. DON-A verified the SA was not notified timely. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated the policy was vague regarding a thorough investigation. However, the administrator stated they have staff sign and date their statements. The facility's undated Procedures for Reporting Suspected Maltreatment indicated the possible maltreatment would be thoroughly investigated. In addition, the administrator stated he was called by the DON on 12/29/15, after she was notified of the incident. An interview was conducted with DON-B on 2/11/16, at 11:30 a.m. DON-B stated RN-F worked on 12/27/15. RN-F had filled out a Dropped Dosage Form for a resident who was on Metoprolol and requested three tablets from the pharmacy. DON-B stated she did the investigation and had not documented this information during the investigation. An interview was conducted with DON-B on 2/11/16, at 12:42 p.m. DON-B stated on 12/29/15, LPN-C checked both of the medication carts for any tampering of other medications. In addition, DON-B stated R1 and R2 were interviewed regarding their pain levels and DON-B verified this information was lacking from the investigation.	F 226		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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	245388	A. BUILDING _____ B. WING _____	C 04/18/2016

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F 431	Continued From page 9 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 observation, interview and document review, the facility failed to develop a policy to ensure Fentanyl (Duragesic) patches were accurately destroyed to minimize potential drug diversion for 1 of 1 resident (R3) reviewed on a Duragesic patch.	F 431		

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F 431	Continued From page 10 Findings included: R3's medical record was reviewed. R3 was diagnosed with a vertebral fracture and back pain. On 8/13/14, R3's physician ordered a Duragesic patch 12 micrograms (mcg) per hour to be changed every 3 days for pain control. On 2/10/16, at 4:30 p.m. licensed practical nurse (LPN)-I removed a Duragesic patch from R3 and then flushed the patch down the toilet. At this time LPN-I was interviewed and stated their system was to flush the patch down the toilet without a witness. An interview was conducted with director of nursing (DON)-A on 2/11/16, at 8:08 a.m. DON-A stated the facility practice was to flush the Duragesic patch down the toilet. DON-A stated it was Okay for one nurse to destroy the Fentanyl patch. DON-A stated there are some evenings there would only be one nurse on duty in addition to the trained medication aide. An interview was conducted with the consulting pharmacist (CP)-G on 3/4/16, at 9:02 a.m. CP-G stated the normal process when removing the Fentanyl patch was to flush it into the sewer system. CP-G stated he was unsure if there would be two nurses available to sign off the disposal on an evening shift. CP-G stated he had not spoken with the facility about changing the current practice. The facility's policy on Disposal of Controlled Substances dated 6/09, indicated when a Fentanyl patch was removed from a resident after the ordered number of hours it would be folded in	F 431		

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F 431	Continued From page 11 half (drug side to the interior) and flushed down the toilet. Staff removing the patch would wear gloves. CMS memo 13-02 dated 11/2/12, indicated staff should dispose of fentanyl patches in the same manner as wasting of any other controlled substances, particularly because the active ingredient is still accessible. Wasting must involve a secure and safe method, so diversion and/or accidental exposure are minimized. Tag F425 requires the facility ' s procedures to address the disposition of all medications.	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 #H5388006 & H5388007. As a result, the following correction orders are issued related to #H5388006 & #H5388007. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 1 Informational 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 interview and document review, the facility failed to ensure residents were free from maltreatment of financial exploitation for 2 of 2	21850		

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21850	Continued From page 2 residents (R1, R2) whose medications were taken by registered nurse (RN)-F for her own personal use. Findings include: R1's medical record was reviewed. R1 was diagnosed with a right total hip replacement and had a physician's order dated 12/14/15, for Oxycodone HCL (used to treat acute pain) 5 milligrams (mg) every 4 hours as needed for pain. R2's medical record was reviewed. R2 was diagnosed with a fractured right femur and had a physician's order dated 10/26/15, for Oxycodone HCL 5 mg every 4 hours as needed for pain. An interview was conducted with licensed practical nurse (LPN)-C on 2/12/16, at 9:03 a.m. LPN-C stated registered nurse (RN)-F had called her at home between 10:30 a.m. and 11:00 a.m. on 12/29/15. RN-F asked LPN-C if she should work for her due to weather conditions. LPN-C declined the offer. RN-F then stated last evening when she worked she had passed out and her arm fell into the narcotic box. LPN-C stated she did not think much about the comment. LPN-C stated she went into work on 12/29/15, at 2:30 p.m. and at 7:00 p.m. nursing assistant (NA)-E stated R2 wanted a pain pill for back pain. LPN-C stated when she took R2's Oxycodone card from the narcotic box, she noticed a lot of tape on the back of both Oxycodone packages. LPN-C stated this seemed odd and she was really alarmed by it. LPN-C stated she did not use a pill that was taped into the package and jokingly said to NA-E, what happened with RN-F last evening? NA-F explained that RN-F had hollered his name and he stated RN-F had her hand in the narcotic drawer. LPN-C stated between 9:00 p.m. and 9:30 p.m. on 12/29/15, she spoke with trained	21850		

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21850	Continued From page 3 medication aide (TMA)-D and asked her what had happened last evening with RN-F. TMA explained that NA-E had requested she come to the South wing and she found RN-F seated in a chair. RN-F requested TMA-D check her blood sugar and blood pressure. RN-F told TMA-D there were a bunch of pills lying loose in the bottom of the narcotic drawer. TMA-D explained that RN-F instructed her to tape the pills back into the Oxycodone packages. LPN-C stated she could not believe it. LPN-C stated at about 10:30 p.m. she looked at the Oxycodone packages and noticed the pills were of different sizes and had different markings. LPN-C stated she then called the director of nursing (DON). LPN-C stated the DON instructed her to put the tampered packages of R1's Oxycodone (2 cards) and R2's Oxycodone (2 cards) in the DON's office and write up a statement. LPN-C stated TMA-D also wrote up a statement for the DON. An interview was conducted with RN-F on 3/4/16, at 1:07 p.m. RN-F stated on the evening of 12/28/15, she pretended to faint and fall into the narcotic box. RN-F stated there were pills that came out of the bubble pack. RN-F admitted she had been taking Oxycodone from R1 and R2 for about 8-10 days prior to 12/28/15. RN-F further stated she had taken approximately 40 tablets of Oxycodone from the two residents for her own personal use. LPN-F stated she would replace the Oxycodone pills with other medications and tape the back of the bubble pack. The facility's undated Abuse/Maltreatment Policies and Procedures indicated residents would have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion.	21850		

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21850	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could update the controlled substance medication policy to address taping and tampering of medication packages. The DON could provide training to all nursing staff. The DON could provide vulnerable adult training to all the nursing staff. The DON could randomly audit narcotic medications to ensure the integrity of the packages. The quality assessment and assurance committee could implement monitoring to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the	21980		

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21980	Continued From page 5 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of financial exploitation was immediately reported to the State agency (SA) and provide evidence of a thorough investigation of potential drug diversion for 1 of 5 incidents reviewed affecting 2 of 2 residents (R1, R2) whose medications were missing. Findings include:	21980		

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21980	Continued From page 6 R1's medical record was reviewed. R1 was diagnosed with status post right total hip replacement and had a physician's order dated 12/14/15, for Oxycodone HCL (used to treat acute pain) 5 milligrams (mg) every 4 hours as needed for pain. R2's medical record was reviewed. R2 was diagnosed with a fractured right femur and had a physician's order dated 10/26/15, for Oxycodone HCL 5 mg every 4 hours as needed for pain. An interview was conducted with licensed practical nurse (LPN)-C on 2/12/16, at 9:03 a.m. LPN-C stated registered nurse (RN)-F had called her at home between 10:30 a.m. and 11:00 a.m. on 12/29/15. RN-F asked LPN-C if she should work for her due to weather conditions. LPN-C declined the offer. RN-F then stated last evening when she worked she had passed out and her arm fell into the narcotic box. LPN-C stated she did not think much about the comment. LPN-C stated she went into work on 12/29/15, at 2:30 p.m. and at 7:00 p.m. nursing assistant (NA)-E stated R2 wanted a pain pill for back pain. LPN-C stated when she took R2's Oxycodone card from the narcotic box, she noticed a lot of tape on the back of both Oxycodone packages. LPN-C stated this seemed odd and she was really alarmed by it. LPN-C stated she did not use a pill that was taped into the package and jokingly said to NA-E, what happened with RN-F last evening? NA-F explained that RN-F had hollered his name and he stated RN-F had her hand in the narcotic drawer. LPN-C stated between 9:00 p.m. and 9:30 p.m. on 12/29/15, she spoke with trained medication aide (TMA)-D and asked her what had happened last evening with RN-F. TMA explained that NA-E had requested she come to the South wing and she found RN-F seated in a	21980		

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21980	Continued From page 7 chair. RN-F requested TMA-D check her blood sugar and blood pressure. RN-F told TMA-D there were a bunch of pills lying loose in the bottom of the narcotic drawer. TMA-D explained that RN-F instructed her to tape the pills back into the Oxycodone packages. LPN-C stated she could not believe it. LPN-C stated at about 10:30 p.m. she looked at the Oxycodone packages and noticed the pills were of different sizes and had different markings. LPN-C stated she then called the director of nursing (DON). LPN-C stated the DON instructed her to put the tampered packages of R1's Oxycodone (2 cards) and R2's Oxycodone (2 cards) in the DON's office and write up a statement. LPN-C stated TMA-D also wrote up a statement for the DON. According to the facility's internal investigation on 12/30/15, the consulting pharmacist (CP)-G and the police were notified of the incident. CP-G examined R1's and R2's medications and confirmed numerous medications had been replaced with other medications which included Metoprolol (a blood pressure medication). The allegation of financial exploitation was not reported to the SA until 1/4/16, (6 days later) according to the investigative report submitted to the SA. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated R1 and R2 had medicare as their payor source at the time of the incident. The administrator stated the facility had purchased their medications and therefore had not viewed the incident as financial exploitation. The administrator stated the day they received direction from their provider group they reported the incident to the SA on 1/4/16.	21980		

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21980	Continued From page 8 An interview was conducted with DON-A on 2/10/16, at 9:57 a.m. DON-A stated according to their policy they have 24 hours to report to the SA. DON-A verified the SA was not notified timely. An interview was conducted with the administrator on 2/11/16, at 8:55 a.m. The administrator stated the policy was vague regarding a thorough investigation. However, the administrator stated they have staff sign and date their statements. The facility's undated Procedures for Reporting Suspected Maltreatment indicated the possible maltreatment would be thoroughly investigated. In addition, the administrator stated he was called by the DON on 12/29/15, after she was notified of the incident. An interview was conducted with DON-B on 2/11/16, at 11:30 a.m. DON-B stated RN-F worked on 12/27/15. RN-F had filled out a Dropped Dosage Form for a resident who was on Metoprolol and requested three tablets from the pharmacy. DON-B stated this information was lacking from the investigation. An interview was conducted with DON-B on 2/11/16, at 12:42 p.m. DON-B stated on 12/29/15, LPN-C checked both of the medication carts for any tampering of other medications. In addition, DON-B stated R1 and R2 were interviewed regarding their pain levels and DON-B verified this information was lacking from the investigation. The facility's undated Procedures for Reporting Suspected Maltreatment indicated if it is determined maltreatment may have occurred, the administrator or his/her delegate will submit a report to the Office of Health Facility Complaints	21980		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 9 (OHFC) on their electronic form. Both of these reports would be submitted within 24 hours of the initial report. Lakeshore Inn will thoroughly investigate the possible maltreatment. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could review and revise the facility Abuse Prevention Policy related to timing of reporting of potential resident maltreatment. The administrator or designee could educate staff related to the policy and monitor to assure the facility is reporting the potential resident maltreatment timely. The quality assessment and assurance committee could randomly audit for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245388 Y1	A. Building B. Wing Y2	6/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 06/07/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 06/07/2016	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 06/07/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00682 Y1	A. Building B. Wing Y2	6/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 06/07/2016	ID Prefix 21980 Reg. # MN St. Statute 626.557 Subd. 3 LSC	Correction Completed 06/07/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO