DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Good Samaritan Society Battle Lake			H5403003	August 15, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
105 Glenhaven Drive			9:15 a.m. to 3:00 p.m.	January 4, 2018
Facility City:			**Investigator's Name and Title:**	
Battle Lake			Jill Hagen, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	56515	Otter Tail		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was financially exploited when the alleged perpetrator (AP) took the resident's narcotic medication.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, financial exploitation occurred when the alleged perpetrator (AP) took opioid (Oxycodone) narcotic pain medication from the resident. In addition, the AP took opioid medication from two other residents.

Resident #1 was cognitively intact and capable of making his/her needs known to staff. Resident #1 had a physician's order for Oxycodone 15 mg (milligrams) three times a day prn (when needed) for generalized pain.

One day following Resident #1 pain assessment, licensed staff discussed with him/her the increased frequency Resident #1 required Oxycodone. Resident #1 denied having increased pain and indicated s/he required one or two doses a day and not every day. The discrepancy concerned the licensed staff who initiated a protocol where Resident #1 provided his/her initials along with the licensed staff dispensing the Oxycodone.

About one month later, Resident #1 requested an Oxycodone. Licensed staff told Resident #1 that the medication administration record and nurse notes indicated s/he received a dose an hour earlier. Resident

#1 denied receiving the dose. The licensed staff showed Resident #1 the page s/he initialed confirming s/he received the dose. Resident #1 said his/her initials had been forged on the signature page.

That evening, management contacted the AP who had dispensed the earlier dose of Oxycodone to Resident #1. The AP admitted to taking Resident #1's Oxycodone tablets for his/her own use. During the same conversation, the AP admitted to taking a few tablets of Oxycodone several months prior, from Resident #2 and another unidentified resident.

Resident #2 was severely cognitively impaired and required the assistance from others for decision making. Resident #2 had a physician's order for Oxycodone 5 mg every six hours as needed for spinal stenosis or a narrowing of the spaces of the spine that caused pain.

Resident #2's medical record revealed staff had not dispensed Oxycodone to Resident #2 in the preceding three months.

When interviewed, Resident #1 stated s/he experienced no uncontrolled pain.

Due to Resident #2's cognition, s/he was not able to recall missing medications.

When interviewed, the AP admitted to taking Resident #1 and Resident #2's Oxycodone tablets for his/her own use. The AP was scheduled full time hours with eight-hour shifts. When needed, the AP often worked an additional four hours or 12-hour shifts. The AP admitted to "targeting" Resident #1 because s/he was prescribed Oxycodone 15 mg; a larger dose than other residents. The AP admitted to taking Resident #1's Oxycodone one to two tablets a shift, for approximately one and one-half years. The AP said s/he took an undetermined amount of Resident #2's Oxycodone several months prior. In addition, the AP admitted to taking one or two Oxycodone tablets from an unidentified resident who was admitted to the facility short term. The AP admitting to signing out the opioid medication on the residents' narcotic log and medication administration record. In addition, the AP falsely documented in the resident's progress notes the medication was given and provided pain relief to the residents. The AP admitted to forging Resident #1's initials. The AP said s/he had a long term addiction to Oxycodone and was requiring more of the medication. The AP admitted her/himself to a drug treatment program.

The police report indicated the AP refused to be interviewed. The report was forwarded to the county attorney.

The AP was suspended and terminated from the facility.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☐ Neglect ☒ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☐ Neglect ☒ Financial Exploitation. This determination was based on the following:

Although the facility had policies in place related to misappropriation of resident property and exploitation and trained the AP on the policies, the AP took the residents' opioid medications for his/her own use. In addition, the AP falsified documentation.

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

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

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

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Other, specify:

Other pertinent medical records:

- [x] Police Report

Additional facility records:

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

☒ 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 reporter(s) ○ Yes ○ No ◉ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

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

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

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

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Three who receive narcotic medication

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Three

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:

☒ Nursing Services
☒ Medication Pass
☒ Dignity/Privacy Issues
☒ Facility Tour
☒ Other: Security of controlled substances

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

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Battle Lake Police Department

Otter Tail County Attorney

Battle Lake City Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2018

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: Project Number H5403003

Dear Mr. Wolf:

On January 26, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 20, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of January 26, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 20, 2018.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on November 20, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our January 26, 2018 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 12, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 25, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 20, 2017, as of January 18, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of January 26, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 20, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 20, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 20, 2018, is to be rescinded.

In our letter of January 26, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 20, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 18, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 6, 2018

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Re: Project Number H5403003

Dear Mr. Wolf:

On November 20, 2017, an investigation was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, to determine if your facility was in compliance with federal and state regulations. The investigator found federal deficiencies and violations.

The CMS form 2567 and state licensing order was sent to you previously. The investigative report is now completed and a copy is enclosed.

If you have questions related to this investigation, please contact the investigator identified in the report.

Thank you for your cooperation.

Sincerely,

Lindsey L Krueger

Lindsey Krueger, Interim Assistant Director
Health Regulation Division
Office of Health Facility Complaints
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4135 Fax: (651) 281-9796
General Information: (651) 201-4201 - 1-800-369-7994

Enclosure

LK/tn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	R-C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification revisit was conducted on February 12, 2018 to follow up on deficiencies issued relate to complaint H5403003. Good Samaritan Society Battle Lake is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 6, 2018

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Re: Enclosed Reinspection Results - Complaint Number H5403003

Dear Mr. Wolf:

On February 12, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on November 20, 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,

Kamala Fiske-Downing

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

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Minnesota Department of Health

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	00146	A. BUILDING: _____ B. WING _____	R-C 02/12/2018

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5403003. Good Samaritan Society Battle Lake was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a	{2 000}		

Minnesota Department of Health

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	00146	A. BUILDING: _____ B. WING _____	R-C 02/12/2018

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

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	245403	A. BUILDING _____ B. WING _____	C 11/20/2017

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5403003. The following deficiency is 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. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		
F 224 SS=D	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN CFR(s): 483.12(b)(1)-(3) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from	F 224		

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 224	Continued From page 1 maltreatment for two of four (R1 and R2) residents reviewed who were prescribed a narcotic medication. A staff member took multiple doses of an Oxycodone, an opioid pain medication from the two residents for their own personal use. Findings include: R1's medical record was reviewed. Review of the facility's Diagnosis Report, not dated, indicated R1's diagnoses included polyneuropathy or damage to nerves that causes pain, osteoporosis or thinning of the bones, venous insufficiency, peripheral vascular disease, chronic kidney disease and diabetes. Review of R1's care plan with a revision date of March 27, 2017, revealed R1 was not able to ambulate and required a self-propelled electric wheelchair for mobility. R1 required staff assistance to complete activities of daily living and two staff with a mechanical sling lift for all transfers. Review of R1's quarterly Minimum Data Set (MDS) dated May 31, 2017, indicated R1 was cognitively intact. Review of the facility's Medication Administration Record (MAR) dated July 2017, revealed R1's physician prescribed Oxycodone an opioid pain medication 15 milligrams (mg) one table by mouth (po) three times a day (tid) as needed (prn) for pain. The MAR indicated the order originated on December 14, 2016. During an interview with R1 on August 15, 2017, at 10:25 a.m. R1 stated a registered nurse (RN)	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 2 unknown date had been in to discuss the amount of Oxycodone R1 was requesting from staff. The RN asked whether R1's pain was worse. Following the conversation, R1 thought about how frequently he needed Oxycodone. Usually R1 tolerated a pain level of six or seven on a scale from one to ten with ten the worst pain. R1 requested oxycodone when his pain was at an eight or nine. There were some days when R1 did not require medication and at most requested the medication one or two times a day. Sometime in May, R1 discussed his concerns with RN-A that he was not using as much Oxycodone as documented by the staff. After that, staff requested R1 initial a sheet of paper along with the RN dispensing the medication every time R1 was given Oxycodone. On July 1, 2017, around 2:00 p.m. R1 requested Oxycodone for generalized pain at eight or nine. RN-B told R1 RN-C gave him the medication at 1:00 p.m. and would have to wait. R1 denied being given Oxycodone by RN-C. RN-B showed R1 the sheet with R1's initials for the 1:00 p.m. dose. R1 said his initials had been forged by RN-C. During an interview on August 15, 2017, at 10:58 a.m. RN-A revealed sometime in May 2017, R1 requested to speak privately with RN-A. R1 denied requesting and taking the amount of Oxycodone documented by the facility. R1 said he rarely required the Oxycodone three times a day. RN-A contacted the director of nursing (DON) and began investigating the dates, times and nurse dispensing the medication to R1. RN-C dispensed the Oxycodone more frequently than other licensed staff. RN-C documented dispensing Oxycodone to R1 up to two times a shift; other licensed staff dispensed none to up to one dose. On May 15, 2017, the facility	F 224		

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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F 224	Continued From page 3 developed a form for R1 to initial with the nurse when given Oxycodone. On July 1, 2017, RN-B contacted RN-A stating around 2:00 p.m. R1 requested Oxycodone 15 milligrams for generalized pain. RN-B told R1 that the MAR indicated RN-C dispensed the medication to R1 at 1:00 p.m.; it was too soon to have the medication. R1 denied asking for and being dispensed the Oxycodone by RN-C. RN-A showed R1 the nurse-resident signature sheet. R1 denied initialing the sheet and said his initials were forged by RN-C. RN-A dispensed the medication to R1 after consulting with the DON. During an interview on August 15, 2017, at 11:42 a.m. the assistant DON (ADON) revealed during a meeting with RN-C on May 15, 2017, RN-C denied taking R1's Oxycodone for her own use. RN-C said she was more attentive than other staff to every residents need for pain medication. Following the discrepancy on July 1, 2017, RN-C was contacted by staff and RN-C admitted to diverting opioid medications from R1 at least one to two times a shift for at least one year. R2's medical record was reviewed. Review of the facility's Diagnosis Report, not dated, revealed R2's diagnoses included dementia, spinal stenosis or a narrowing of the spaces in the spine, chronic kidney disease and heart failure. Review of R2's quarterly MDS dated June 7, 2017, indicated R2 was cognitively impaired with limited memory. Review of R2's MAR dated July 2017, revealed R2 physician prescribed oxycodone 5 mg po every six hours prn for pain. The MAR indicated the order originated on October 14, 2015.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	C 11/20/2017

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F 224	Continued From page 4 Review of R2's MAR's dated May 1, 2017 through May 31, 2017, June 1, 2017, through June 30, 2017, and July 1, 2017 through July 31, 2017, revealed R2 required no doses of the prn Oxycodone. Review of R2's Pain Assessment dated July 29, 2017, indicated R2 required no changes to the recommended pain management plan. R2's pain management plan consisted of rest, applying ice and repositioning along with a Duragesic patch or topical opioid for pain, Tylenol 1000 mg tid or three times a day, BioFreeze a non-narcotic gel and Oxycodone as needed. During an interview on August 15, 2017, at 9:20 a.m. the DON revealed RN-C admitted to taking a Oxycodone for her own use from R2. RN-C said she had stopped taking R2's Oxycodone several months prior. During an interview on August 15, 2017, at 10:58 a.m. RN-A revealed a few months prior, she became aware RN-C was the only licensed staff dispensing Oxycodone to R2. When asked, RN-C said she was more aware of R2's pain and provided the medication to maintain R2's comfort. During an interview on October 16, 2017, at 12:06 p.m. RN-C admitted to taking Oxycodone tablets from R1 and R2. RN-C began taking Oxycodone tablets from R1 and R2 about one year earlier. RN-C said she was very dependent on Oxycodone and admitted to increasing the frequency of taking Oxycodone for the residents. RN-C admitted to taking R1's Oxycodone at least every other to every day she worked, one to two times a shift. R1 was the "target" because R1 had	F 224		

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F 224	Continued From page 5 a larger dose prescribed up to three times a day which R1 rarely needed. RN-C was able to sign out the medication in the narcotic book, sign the MAR for R1 to indicate R1 had the medication and use it for herself. RN-C could not remember when or how many Oxycodone tablets she took from R1. Review of the facility's policy and procedure titled Controlled Substances with a revision date of May 2016, stated every time the keys that secured medication changed from one nurse to another nurse, the oncoming and off going nurse worked together to count all controlled substances. Review of the facility's policy and procedure titled Abuse and Neglect with a revision date of November 2016, stated, residents had the right to be free from misappropriation of resident property and exploitation.	F 224		

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5403003. As a result the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of	2 000		

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

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2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from maltreatment for two of four (R1 and R2) residents reviewed who were prescribed a narcotic medication. A staff member took multiple doses of an Oxycodone, an opioid pain medication from the two residents for their own personal use. Findings include: R1's medical record was reviewed. Review of the facility's Diagnosis Report, not dated, indicated	21850		

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21850	Continued From page 2 R1's diagnoses included polyneuropathy or damage to nerves that causes pain, osteoporosis or thinning of the bones, venous insufficiency, peripheral vascular disease, chronic kidney disease and diabetes. Review of R1's care plan with a revision date of March 27, 2017, revealed R1 was not able to ambulate and required a self-propelled electric wheelchair for mobility. R1 required staff assistance to complete activities of daily living and two staff with a mechanical sling lift for all transfers. Review of R1's quarterly Minimum Data Set (MDS) dated May 31, 2017, indicated R1 was cognitively intact. Review of the facility's Medication Administration Record (MAR) dated July 2017, revealed R1's physician prescribed Oxycodone an opioid pain medication 15 milligrams (mg) one table by mouth (po) three times a day (tid) as needed (prn) for pain. The MAR indicated the order originated on December 14, 2016. During an interview with R1 on August 15, 2017, at 10:25 a.m. R1 stated a registered nurse (RN) unknown date had been in to discuss the amount of Oxycodone R1 was requesting from staff. The RN asked whether R1's pain was worse. Following the conversation, R1 thought about how frequently he needed Oxycodone. Usually R1 tolerated a pain level of six or seven on a scale from one to ten with ten the worst pain. R1 requested oxycodone when his pain was at an eight or nine. There were some days when R1 did not require medication and at most requested the medication one or two times a day. Sometime in May, R1 discussed his concerns with RN-A that	21850		

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21850	Continued From page 3 he was not using as much Oxycodone as documented by the staff. After that, staff requested R1 initial a sheet of paper along with the RN dispensing the medication every time R1 was given Oxycodone. On July 1, 2017, around 2:00 p.m. R1 requested Oxycodone for generalized pain at eight or nine. RN-B told R1 RN-C gave him the medication at 1:00 p.m. and would have to wait. R1 denied being given Oxycodone by RN-C. RN-B showed R1 the sheet with R1's initials for the 1:00 p.m. dose. R1 said his initials had been forged by RN-C. During an interview on August 15, 2017, at 10:58 a.m. RN-A revealed sometime in May 2017, R1 requested to speak privately with RN-A. R1 denied requesting and taking the amount of Oxycodone documented by the facility. R1 said he rarely required the Oxycodone three times a day. RN-A contacted the director of nursing (DON) and began investigating the dates, times and nurse dispensing the medication to R1. RN-C dispensed the Oxycodone more frequently than other licensed staff. RN-C documented dispensing Oxycodone to R1 up to two times a shift; other licensed staff dispensed none to up to one dose. On May 15, 2017, the facility developed a form for R1 to initial with the nurse when given Oxycodone. On July 1, 2017, RN-B contacted RN-A stating around 2:00 p.m. R1 requested Oxycodone 15 milligrams for generalized pain. RN-B told R1 that the MAR indicated RN-C dispensed the medication to R1 at 1:00 p.m.; it was too soon to have the medication. R1 denied asking for and being dispensed the Oxycodone by RN-C. RN-A showed R1 the nurse-resident signature sheet. R1 denied initialing the sheet and said his initials were forged by RN-C. RN-A dispensed the medication to R1 after consulting with the DON.	21850		

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21850	Continued From page 5 and Oxycodone as needed. During an interview on August 15, 2017, at 9:20 a.m. the DON revealed RN-C admitted to taking a Oxycodone for her own use from R2. RN-C said she had stopped taking R2's Oxycodone several months prior. During an interview on August 15, 2017, at 10:58 a.m. RN-A revealed a few months prior, she became aware RN-C was the only licensed staff dispensing Oxycodone to R2. When asked, RN-C said she was more aware of R2's pain and provided the medication to maintain R2's comfort. During an interview on October 16, 2017, at 12:06 p.m. RN-C admitted to taking Oxycodone tablets from R1 and R2. RN-C began taking Oxycodone tablets from R1 and R2 about one year earlier. RN-C said she was very dependent on Oxycodone and admitted to increasing the frequency of taking Oxycodone for the residents. RN-C admitted to taking R1's Oxycodone at least every other to every day she worked, one to two times a shift. R1 was the "target" because R1 had a larger dose prescribed up to three times a day which R1 rarely needed. RN-C was able to sign out the medication in the narcotic book, sign the MAR for R1 to indicate R1 had the medication and use it for herself. RN-C could not remember when or how many Oxycodone tablets she took from R1. Review of the facility's policy and procedure titled Controlled Substances with a revision date of May 2016, stated every time the keys that secured medication changed from one nurse to another nurse, the oncoming and off going nurse worked together to count all controlled substances.	21850		

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21850	Continued From page 6 Review of the facility's policy and procedure titled Abuse and Neglect with a revision date of November 2016, stated, residents had the right to be free from misappropriation of resident property and exploitation. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure each resident's bill of rights are upheld and residents are free from maltreatment. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		