

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Capitol View Transitional Care			Report Number: H5534013	Date of Visit: October 25, 2016		
Facility Address: 640 Jackson Street			Time of Visit: 12:15 p.m. to 4:30 p.m. March 2, 202			
Facility City: Saint Paul			Investigator's Name and Title: Carol Bode, R.N., Special Investigator			
State:	ZIP:	County:				
Minnesota Nursing Home	55101	Ramsey				

Allegation(s):

It is alleged that three residents were exploited when the alleged perpetrator (AP) took the residents' narcotic medication several times a week that resulted in residents not getting their pain medication.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- |X| 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 multiple narcotic medication from three resident's over approximately two months. There was no indication any of the residents suffered any pain as a result.

Resident #1 and #2 were at the facility for post operative care and were receiving narcotic medication for pain. Resident #3 was receiving narcotics for leg pain.

During Resident #1's discharge, the nurse reviewed the remaining narcotic medication with Resident #1. Resident #1 stated s/he did not request or received the amount of pain medication doses that were recorded in the record as administered. The nurse notified administration of the discrepancy. Additional residents were interviewed and similar comments were obtained from Resident #2 and Resident #3.

Resident #1 was interviewed stating s/he did not take as many medications as documented by the facility. The Resident only took one narcotic at any given time and the documentation indicated she received two tablets.

Resident #2 was interviewed and stated s/he did not like to take narcotics and denied taking all the narcotics documented in the medical record.

Resident #3 was not available for interview.

Facility Name: Capitol View Transitional Care Report Number: H5534013

The AP was interviewed and admitted to taking narcotics from residents residing in the facility. The AP stated she would sign out two medications, give one to the resident and keep the other. In addition, the AP would sign out a narcotic medication when the resident didn't ask for it and keep it for her/himself. The AP was unable to identify which residents, how often, or how much narcotic medication was taken from the residents.

Based on a review of 20-30 narcotics.	of resident #1, #2, and #3's med	dical records it is suspected that the AP took between							
The facility reported	I the incident to the Board of N	Nursing and terminated the AP.							
Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)									
Under the Minnesota	a Vulnerable Adults Act (Minn	nesota Statutes, section 626.557):							
☐ Abuse ☐ Neglect ☐ Financial Exploitation									
Substantiated ■	☐ Not Substantiated	☐ Inconclusive based on the following information:							
Mitigating Factors:	!! ! M:	tion (2)(557 publication (2) (2) was considered and it was							
	ors" in Minnesota Statutes, sec Individual(s) and/or Fac	tion 626.557, subdivision 9c (c) were considered and it was							
		loitation. This determination was based on the following:							
The facility had poli	cies and procedures in place to	prevent drug diversion and financial exploitation. The AP es pertaining to financial exploitation.							
substantiated against possible inclusion of	t an identified employee, this re the finding on the abuse regist	to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services provisions of the background study requirements under							
Compliance:									
•		42 CFR, Part 483, subpart B) - Compliance Not Met or Long Term Care Facilities (42 CFR, Part 483, subpart B),							
Deficiencies are issu	ed on form 2567: 🗵 Yes	□ No							
(The 2567 will be av	ailable on the MDH website.)								
_		s Chapter 4658) - Compliance Not Met Nursing Homes (MN Rules Chapter 4658) were not met.							
State licensing order	rs were issued: 🕱 Yes	□ No							
(State licensing orde	ers will be available on the MDI	H website.)							

Facility Name: Capitol View Transitional Care

Report Number: H5534013

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 9 - Financial exploitation
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

| Medical Records

Faci	lity Name: Capitol View Transitional Care	Report Number: H5534013
X	Care Guide	
X	Medication Administration Records	
X	Nurses Notes	
X	Assessments	
X	Physician Orders	
X	Physician Progress Notes	
X	Care Plan Records	
X	Facility Incident Reports	
Oth	er pertinent medical records:	
λda	litional facility records:	
X	Resident/Family Council Minutes	
X	Staff Time Sheets, Schedules, etc.	
X	Facility Internal Investigation Reports	
X	Personnel Records/Background Check, etc.	
X	Facility In-service Records	
X	Facility Policies and Procedures	
Nur	mber of additional resident(s) reviewed: Three	
Wei	re residents selected based on the allegation(s)? Yes No N/A	- A White Control
Spe	cify:	
Wei	re resident(s) identified in the allegation(s) present in the facility at the time of th	ne investigation?
0	Yes ● No ○ N/A	
Spe	cify: Discharged	
Τ. /	The fellowing supportant and the desired distributions and the distribution of the din	
-675555	erviews: The following interviews were conducted during the investigation: erview with complainant(s) • Yes O No O N/A	
	ecify:	
•	nable to contact complainant, attempts were made on:	
Dat		Time:
Inte	erview with family: O Yes O No N/A Specify:	
	you interview the resident(s) identified in allegation:	
()	Yes ONO N/A Specify:	

Facility Name: Capitol View Transitional Care Report Number: H5534013 Did you interview additional residents? () Yes No Total number of resident interviews:Two Interview with staff:

Yes \bigcirc No \bigcirc N/A Specify: **Tennessen Warnings** Tennessen Warning given as required:

Yes O No Total number of staff interviews: Six Physician Interviewed: Yes No No Physician Assistant Interviewed: Yes ○ No Interview with Alleged Perpetrator(s):

Yes \bigcirc 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 O No Were contacts made with any of the following: ☐ Emergency Personnel 🗷 Police Officers ☐ Medical Examiner ☐ Other: Specify Observations were conducted related to: Nursing Services **X** Call Light Infection Control **Medication Pass** X Cleanliness X Dignity/Privacy Issues X **Facility Tour** X N/A Was any involved equipment inspected:

Yes \bigcirc No Was equipment being operated in safe manner: Yes N/A Specify: Were photographs taken: Yes No

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Facility Name: Capitol View Transitional Care

Report Number: H5534013

Minnesota Board of Nursing

Minnesota Board of Pharmacy

The Office of Ombudsman for Long-Term Care

Saint Paul Police Department

Ramsey County Attorney

Saint Paul City Attorney

PRINTED: 01/11/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245534	B. WING				C 11/2017
	PROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 540 JACKSON STREET SAINT PAUL, MN 55101	1 01/	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	FO	000			
		andard survey was conducted #H5534013. As a result, the es are issued.					
F 225 SS=D	signature is not req page of the CMS-2 submission of the F verification of comp 483.13(c)(1)(ii)-(iii), INVESTIGATE/REI	, (c)(2) - (4) PORT	F2	225			
	been found guilty o mistreating residen had a finding enter- registry concerning of residents or mis- and report any kno court of law agains indicate unfitness f	ot employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or to the State nurse aide registry					
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					
	violations are thoro prevent further pote	ave evidence that all alleged bughly investigated, and must ential abuse while the					
LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		` COM	E SURVEY PLĖTED
		245534	B. WING				C 11/ 2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 640 JACKSON STREET SAINT PAUL, MN 55101	CODE	01/	11/2011
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F 225	The results of all into the administrator representative and with State law (inclucertification agency incident, and if the	rogress. vestigations must be reported	F 2	25			
	by: Based on interview facility failed to report misappropriation of and the administrat	NT is not met as evidenced and document review the ort timely an allegation of property to the state agency or for three of three residents eviewed when staff diverted in					
	the facility on June included spondylos R1 was cognitively 6/4/2016, indicated medication as orde notify physician as administration reco 6/23/2016, showed (mg) 1-2 tablets as pain. In addition, ty hours for pain as no investigation it was eight 5 mg tablets or	viewed. R1 was admitted to 4, 2016 with diagnoses that isthesis in the lumbar region. intact. R1's care plan dated post-op pain monitoring and red., reposition as needed, needed. Medication rd (MAR) dated 6/4/2016 to oxycodone five (5) milligrams needed every four hours for ylenol 650 mg every eight (8) eeded. During the facilities identified R1 was missing over 19 day admission.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		СОМ	E SURVEY PLETED
		245534	B. WING				C 11/ 2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 640 JACKSON STREET SAINT PAUL, MN 55101	CODE	017	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 225	included a crushing and a cervical fract R2's care plan date pain monitoring an reposition as need Medication adminis 5/12/2016 to 7/1/20 every eight hours a before and after thing every four (4) to needed. During the identified R2 was nover the 43 day ad R3's record was rethe facility on May included osteomye cellulitis of left lowestaphylococcus au cognitively intact. Findicated post-op pas ordered, reposit as needed. Medica (MAR) dated 5/20/20 oxycodone 5 mg eineeded for pain. Dit was identified R3 over the 39 day ad The alleged misapinarcotic's was not immediately for 42 the five day investigate agency as reconstructed in the state agency as a state agency as reconstructed in the state agency as a state agency as reconstructed in the sta	12, 2016 with diagnoses that g injury with fractured femur ture. R2 was cognitively intact. ed 6/1/2016, indicated post-op d medication as ordered, ed, notify physician as needed. Stration record (MAR) dated 216, showed oxycodone 5 mg as needed for pain, and to offer erapies. In addition tylenol 650 to eight (8) hours for pain as a facilities investigation, it was missing six to ten, 5 mg tablets mission. Viewed. R3 was admitted to 20, 2016 with diagnoses that ditis, left ankle and foot, er limb, methicillin susceptible reus infection. R3 was a3's care plan dated 5/20/2016, pain monitoring and medication ation as needed, notify physician ation administration record 2016 to 6/28/2016, showed very 6 hours for pain as uring the facilities investigation, was missing six 5 mg tablets mission. Propriation of R1, R2, and R3's reported to state agency days after the allegation and gation was not submitted to the	F 2	25			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SURPLIER/CUA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245534	B. WING		01	C / 11/2017
	PROVIDER OR SUPPLIER L VIEW TRANSITIONA	AL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 640 JACKSON STREET SAINT PAUL, MN 55101		,11,2317
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 225	between 5/12/2016 investigation indical diverted. LPN-A adhuman resources minternal investigation missing from R1 eight six tabletsof oxycodoxycodone diverted board of nursing. The state agency (SA) in the agency (SA) in the agency (SA) in the agency (SA) in the administrator being and was terminated. An interview on October the administrator state agency (SA) in the	S to 6/24/2016. The facilities ted the medications were mitted to the administrator and nanager of the diversion. An in indicated 20-26 tablets ght tablets of oxycodone, R2 done, and R3 6-10 tablets of d. A report was made to the The event was not reported to mmediately. Itober 25th 2016, at 12:50 p.m, HR)-E stated LPN-A was the investigation of the diverted dimitted to HR-E and the responsible for the diversion of the diversi	F2	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
						(c
		245534	B. WING			01/	11/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
CAPITOL	. VIEW TRANSITIONA	AL CARE CENTER		640 JACKSON STREET			
				SAINT PAUL, MN 55101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	The facility policy at abuse, neglect, and 2013 indicated each abuse, neglect, mis misappropriation of mental abuse, verb incidences must be state agency (SA). 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negle	of some pain medication. Ind procedure entitled patient if mistreatment dated January in resident shall be free from streatment, exploitation and property. Abuse shall include: property, physical abuse, all abuse and neglect. All reported immediately to the P/IMPLMENT, ETC POLICIES	F 2				
	by: Based on interview facility failed to implimmediately report misapproriation of p (SA) for three of thr reviewed when staff medications. Findings include: The facility policy at abuse, neglect, and 2013 indicated each abuse, neglect, mis	property to the state agency ee residents (R1, R2, R3)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245534	B. WING		01	/11/2017
	OVIDER OR SUPPLIER	AL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 640 JACKSON STREET SAINT PAUL, MN 55101		, ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
n nii S Ttirrii a Fti ii F 6 n na 6 (phi ii e Fti ii a Fpr M 5 e b	mental abuse, verb necidences must be SA. The alleged narcoti to state agency immegulation and policinvestigation was nearly agency. Al's record was revene facility on June necluded spondylosis as cognitively (3/4/2016, indicated nedication as ordered in the facility on June necluded spondylosis as revene facility on June necluded and the second may 1-2 tablets as pain. In addition typours for pain as nearly sight 5 mg tablets of the facility on May 1 included a crushing and a cervical fraction as needed and from a cervical fraction and from a cervical fraction and fraction adminis and fraction and fractio	ge 5 property, physical abuse, all abuse and neglect. All reported immediately to the c diversion was not reported nediately as required by by for 42 days and the five day of submitted to the state viewed. R1 was admitted to 4, 2016 with diagnoses that isthesis in the lumbar region. intact. R1's care plan dated post-op pain monitoring and red., reposition as needed, needed. Medication rd (MAR) dated 6/4/2016 to oxycodone five (5) milligrams needed every four hours for lenol 650 mg every eight (8) reded. During the facilities identified R1 was missing over 19 day admission. Viewed. R2 was admitted to 2, 2016 with diagnoses that injury with fractured femurure. R2 was cognitively intact. d 6/1/2016, indicated post-op diagnoses and contify physician as needed. In a diagnose of the property	F 2.	26		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245534	B. WING		0	C 1/11/2017
	PROVIDER OR SUPPLIER	AL CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 640 JACKSON STREET SAINT PAUL, MN 55101		.,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 226	R3's record was retthe facility on May 2 included osteomyel cellulitis of left lowe staphylococcus aur cognitively intact. Rindicated post-op pas ordered, repositias needed. Medica (MAR) dated 5/20/2 oxycodone 5 mg eveneded for pain. Duidentified R3 was mithe 39 day admissional An event report dat licensed practical marcotic diversion of June 24, 2016. The indicated the medical admitted to the admiresources manager investigation indicated the medical investigation indicated. A report work mursing. The event agency (SA) immediated in the resources of coxycodone, and R3 diverted. A report work interview on Octadministrator stated being discharged from discharge process, remaining narcotics received all of the resources and resources of the received all of the resources and resources of the received all of the resources and resources of the resour	nissing six to ten, 5 mg tablets mission. viewed. R3 was admitted to 20, 2016 with diagnoses that itis, left ankle and foot, or limb, methicillin susceptible reus infection. R3 was 3's care plan dated 5/20/2016, ain monitoring and medication from as needed, notify physician ation administration record 2016 to 6/28/2016, showed very 6 hours for pain as uring the investigation, it was hissing six 5 mg tablets over on. ed June 24, 2016, indicated urse (LPN)-A suspected occurring May 12, 2016, to a facilities investigation reations were diverted. LPN-A ministrator and human of the diversion. An internal ted 20-26 tablets missing from oxycodone, R2 six tabletsof as made to the board of a was not reported to state	F 2	26		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT DEPLAY OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				ATE SURVEY OMPLETED	
		245534	B. WING			C 1/11/2017
NAME OF F	PROVIDER OR SUPPLIER	240004		STREET ADDRESS, CITY, STATE, ZIP CO		1/11/2017
CAPITOL	VIEW TRANSITIONA	AL CARE CENTER		640 JACKSON STREET SAINT PAUL, MN 55101		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	practical nurse (LPI suspect. LPN-A wa narcotic diversion in 2016, LPN-A was to board of nursing. An interview on Oct LPN-A admitted to residents. LPN-A st remember who the taken. LPN-A admit giving the residents always	ge 7 N)-A was identified as a as suspended pending the nvestigation. On June 28, erminated, and reported to the tober 27, 2016 at 3:58 p.m. diverting narcotics from ated being unable to residents were or amounts ated to signing out two and one for example. LPN-A said as got some pain medication atment for this problem.	F 2	26		

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: **B WING** 00498 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 JACKSON STREET CAPITOL VIEW TRANSITIONAL CARE CENTEF** SAINT PAUL, MN 55101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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 #H5534013. 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

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
71101011	or connection	DERTH IO THOMBET.	A. BUILDING:				
		00498	B. WING		01/1	; 1/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CAPITOL VIEW TRANSITIONAL CARE CENTEF 640 JACKSON STREET SAINT PAUL, MN 55101							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	.ge 1	2 000				
	Health Facility Com Place, Suite 220, S 55164-0970.	plaints; 85 East Seventh t. Paul, Minnesota,					
21850	MN St. Statute 144 Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850				
	Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non-physical pain or injuconduct intended to distress. Every res non-therapeutic che except in fully docu authorized in writing resident's physician period of time, and	om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the therapeutic infliction of ary, or any persistent course of o produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as g after examination by a in for a specified and limited only when necessary to infrom self-injury or injury to					
	by: Based on interview facility failed to ensi- resident (R1, R2, a from maltreatment	ent is not met as evidenced and document review, the ure residents three of three and R3) reviewed were free when an employee financially nd R3 by diverting narcotic	,				
	Findings include:						
	the facility on June included spondylos	viewed. R1 was admitted to 4, 2016 with diagnoses that isthesis in the lumbar region. intact. R1's care plan dated					

Minnesota Department of Health

STATE FORM

PRINTED: 01/11/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 01/11/2017 00498 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 JACKSON STREET CAPITOL VIEW TRANSITIONAL CARE CENTER** SAINT PAUL, MN 55101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21850 Continued From page 2 21850 6/4/2016, indicated post-op pain monitoring and medication as ordered., reposition as needed, notify physician as needed. Medication administration record (MAR) dated 6/4/2016 to 6/23/2016, showed oxycodone five (5) milligrams (mg) 1-2 tablets as needed every four hours for pain. In addition tylenol 650 mg every eight (8) hours for pain as needed. During the facilities investigation it was identified R1 was missing eight 5 mg tablets over 19 day admission. R2's record was reviewed. R2 was admitted to the facility on May 12, 2016 with diagnoses that included a crushing injury with fractured femur and a cervical fracture. R2 was cognitively intact. R2's care plan dated 6/1/2016, indicated post-op pain monitoring and medication as ordered. reposition as needed, notify physician as needed. Medication administration record (MAR) dated 5/12/2016 to 7/1/2016, showed oxycodone 5 mg every eight hours as needed for pain, and to offer before and after therapies. In addition tylenol 650 mg every four (4) to eight (8) hours for pain as needed. During the facilities investigation, it was identified R2 was missing six to ten, 5 mg tablets over the 43 day admission. R3's record was reviewed. R3 was admitted to the facility on May 20, 2016 with diagnoses that included osteomyelitis, left ankle and foot, cellulitis of left lower limb, methicillin susceptible staphylococcus aureus infection. R3 was cognitively intact. R3's care plan dated 5/20/2016,

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indicated post-op pain monitoring and medication as ordered, reposition as needed, notify physician as needed. Medication administration record (MAR) dated 5/20/2016 to 6/28/2016, showed oxycodone 5 mg every 6 hours for pain as needed for pain. During the investigation, it was identified R3 was missing six 5 mg tablets over

(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00498	B. WING		C 01/11/2017		
NAME OF PROVIDER OR SUPPLIER CAPITOL VIEW TRANSITIONAL CARE CENTEF STREET ADDRESS, CITY, STATE, ZIP CODE 640 JACKSON STREET SAINT PAUL, MN 55101							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE COMPLETE		
21850	the 39 day admission. The narcotic diversing agency immediately policy for 42 days, investigation was not agency. An event report datalicensed practical marcotic diversion of June 24, 2016. The indicated the medical admitted to the admiresources manager investigation indicated R1 eight tablets of coxycodone, and R3 diverted. A report with mursing. The event agency (SA) immediately (SA) immedia	ion was not reported to state y as required by regulation and n addition, a five day ot submitted to the state ed June 24, 2016, indicated urse (LPN)-A suspected occurring May 12, 2016, to a facilities investigation eations were diverted. LPN-A ministrator and human of the diversion. An internal ted 20-26 tablets missing from poxycodone, R2 six tabletsof 6-10 tablets of oxycodone as made to the board of was not reported to state	21850				

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C 01/11/2017 00498 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 JACKSON STREET CAPITOL VIEW TRANSITIONAL CARE CENTER** SAINT PAUL, MN 55101 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 21850 Continued From page 4 board of nursing. An interview on October 27, 2016 at 3:58 p.m. LPN-A admitted to diverting narcotics from residents. LPN-A stated being unable to remember who the residents were or amounts taken. LPN-A admitted to signing out two and giving the resident one for example. LPN-A said the residents always got some pain medication and has been in treatment for this problem. An interview on October 31, 2016, at 10:53 a.m. officer (O)-C stated the event was not reported to the police and on October 31, 2016, at 11:23 a.m. security (S)-B confirmed. The facility policy and procedure entitled patient abuse, neglect, and mistreatment dated January 2013 indicated each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Abuse shall include: misappropriation of property, physical abuse, mental abuse, verbal abuse and neglect. All incidences must be reported immediately to the state agency (SA). The diversion was not reported to state agency immediately as required by regulation and policy for 42 days, in addition, a five day investigation was not submitted to the state agency. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could

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requirement.

monitor incident reports for implementation of this

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 01/11/2017 00498 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **640 JACKSON STREET CAPITOL VIEW TRANSITIONAL CARE CENTER** SAINT PAUL, MN 55101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 Continued From page 5 21850 TIME PERIOD FOR CORRECTION: Twenty One (21) days. 21980 MN St. Statute 626.557 Subd. 3 Reporting -21980 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 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

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reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause

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R1 was cognitively intact. R1's care plan dated 6/4/2016, indicated post-op pain monitoring and medication as ordered., reposition as needed, notify physician as needed. Medication

administration record (MAR) dated 6/4/2016 to 6/23/2016, showed oxycodone five (5) milligrams (mg) 1-2 tablets as needed every four hours for pain. In addition tylenol 650 mg every eight (8) hours for pain as needed. During the facilities investigation it was identified R1 was missing

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agency.

The narcotic diversion was not reported to state agency immediately as required by regulation and

An event report dated June 24, 2016, indicated

policy for 42 days, in addition, a five day investigation was not submitted to the state

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board of nursing.

2016, LPN-A was terminated, and reported to the

An interview on October 27, 2016 at 3:58 p.m. LPN-A admitted to diverting narcotics from residents. LPN-A stated being unable to remember who the residents were or amounts taken. LPN-A admitted to signing out two and giving the resident one for example. LPN-A said the residents always got some pain medication

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00498 01/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 640 JACKSON STREET **CAPITOL VIEW TRANSITIONAL CARE CENTER** SAINT PAUL, MN 55101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ΙD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 21980 Continued From page 9 21980 and has been in treatment for this problem. An interview on October 31, 2016, at 10:53 a.m. officer (O)-C stated the event was not reported to the police and on October 31, 2016, at 11:23 a.m. security (S)-B confirmed. The facility policy and procedure entitled patient abuse, neglect, and mistreatment dated January 2013 indicated each resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. Abuse shall include: misappropriation of property, physical abuse, mental abuse, verbal abuse and neglect. All incidences must be reported immediately to the state agency (SA). The diversion was not reported to state agency immediately as required by regulation and policy for 42 days, in addition, a five day investigation was not submitted to the state agency. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER A. Building B. Wing			STRUCTION	DATE OF REVISIT Y2 2/14/2017			
	FACILITY L VIEW TRANSI	TIONAL CARE CENTER		640 JACKSON STRE	STREET ADDRESS, CITY, STATE, ZIP CODE 640 JACKSON STREET SAINT PAUL, MN 55101		
program, corrected provision	to show those d I and the date su	eficiencies previously rep ich corrective action was :	orted on the CMS-2 accomplished. Eacl	, Medicaid and/or Clinical Labora 567, Statement of Deficiencies a n deficiency should be fully ident n the CMS-2567 (prefix codes sl	ind Plan of Correction, th ified using either the regu	at have been Ilation or LSC	
ITEM DATE		ITEM	DATE	ITEM	DATE		
Y4		Y 5	Y4	Y5	Y4	Y5	
ID Prefix	F0225	Correction	ID Prefix F0226	Correction	ID Prefix	Correction	
Reg.#	483.13(c)(1)(ii)-(ii - (4)	i), (c)(2) Completed	483.13 Reg. #	(c) Completed	Reg. #	Completed	
LSC		01/20/2017	LSC	01/20/2017	LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg.#		Completed	Reg.#	Completed	Reg. #	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg.#		Completed	Reg. #	Completed	Reg.#	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg.#		Completed	Reg. #	Completed	Reg.#	Completed	
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction	
Reg.#		Completed	Reg.#	Completed	Reg. #	Completed	
LSC		· · · · · · · · · · · · · · · · · · ·	LSC		LSC		
REVIEWED BY STATE AGENCY REVIEWED BY AW/KJ		DATE 02/22/2017	SIGNATURE OF SURVEYOR	37786	DATE 02/14/2017		
REVIEWED BY CMS RO (INITIALS)		DATE	TITLE	<i>011</i> 00	DATE		
FOLLOWUP TO SURVEY COMPLETED ON 1/11/2017			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			YES NO	
Form CMS - 2567B (09/92) EF (11/06)			Page 1 of 1 EVENT ID:): QIRC12	

STATE FORM: REVISIT REPORT PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building B. Wing 2/14/2017 00498 Y1 **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE CAPITOL VIEW TRANSITIONAL CARE CENTER 640 JACKSON STREET SAINT PAUL, MN 55101 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 DATE DATE ITEM DATE ITEM **Y4 Y**5 Y4 **Y**5 **Y**4 Y5 ID Prefix 21850 ID Prefix **ID Prefix** Correction Correction 21980 Correction MN St. Statute 144.651 MN St. Statute 626.557 Reg.# Completed Completed Reg. # Completed Reg. # Subd. 14 Subd. 3 01/20/2017 01/20/2017 LSC LSC LSC ID Prefix Correction **ID Prefix** Correction ID Prefix Correction Reg.# Completed Reg. # Completed Reg.# Completed LSC LSC LSC ID Prefix **ID Prefix** ID Prefix Correction Correction Correction Reg.# Completed Reg.# Reg.# Completed Completed LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Reg.# Completed Completed Reg.# Completed LSC LSC LSC **ID Prefix** ID Prefix Correction Correction **ID Prefix** Correction Reg.# Completed Reg. # Completed Reg. # Completed LSC LSC LSC REVIEWED BY REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) AW/KJ 02/22/2017 37786 02/14/2017 **REVIEWED BY** REVIEWED BY DATE TITLE DATE (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? 1/11/2017 YES NO Page 1 of 1 EVENT ID: