DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Champlin GW LLC			HL25047002	July 13, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
11469 Jefferson Court N			9:00 a.m. to 6:00 p.m.	September 24, 2017
Facility City:			**Investigator's Name and Title:**	
Champlin			Meghan Schulz, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55316	Hennepin		

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was financially exploited when alleged perpetrator (AP) took a controlled substance, opioid medication from the client.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

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

☒ State Statutes Chapters 144 and 144A

Conclusion:

Base on a preponderance of evidence, financial exploitation is substantiated. The alleged perpetrator (AP) admitted to taking controlled substance, opioid medications from clients.

The client received services from a provider licensed as a comprehensive home care provider, including medication management. The client had a prescription for Oxycontin (a controlled substance, opioid medication).

The facility received an Oxycontin delivery on an evening shift and it contained one staff signature on the evening of delivery, and one staff signature from the next day.

During an interview, facility management said the client was supposed to get 60 Oxycontin, but only 44 were present. The additional Oxycontin could not be found and the pharmacy told management the delivery was the full amount.

During interviews, neither staff person that signed recalled the specific delivery. One staff member states controlled substances are always counted into the medication cart on delivery, and the other staff said that evening deliveries of controlled substances are placed on the nurse's desk. The nurse's desk is behind a

locked door where multiple staff have access. The AP was the only staff that had a key to the back stock of controlled medications.

During interviews, multiple staff said that two staff should be signing-off on controlled substance deliveries. Documentation and interviews reflect that two staff are not always signing-off.

During an interview, the pharmacist said the pharmacy was never informed of a discrepancy in the medication according to the records. S/he said the pharmacy would do an investigation if a discrepancy was reported. According to pharmacy documentation, 60 tablets of Oxycontin were delivered to the facility and one staff member signed-off.

During an interview, the AP did not admit to taking the Oxycontin from the specific client in the allegation. Later, in an email, the AP admitted to taking medications from other clients. The AP wrote that s/he was not sure if s/he took the client's Oxycontin specifically, but said that it was possible.

The police did not investigate the client's Oxycontin, but investigated other missing controlled medication allegations at the facility. The AP admitted to police that s/he took controlled medications from other clients. The police pursued criminal charges.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

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

☐ Abuse ☐ Neglect ☒ Financial Exploitation

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

Mitigating Factors:

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

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

The facility failed to ensure an effective medication management process for controlled substances and did not implement updated procedures after repeated incidents. The AP took controlled medications.

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 Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

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

State licensing orders were issued: ☒ Yes ☐ No

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

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 9 - Financial exploitation

"Financial exploitation" means:

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

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

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

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

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

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

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

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

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

The Investigation included the following:

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

- [x] Medical Records
- [x] Medication Administration Records
- [ ] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

- [x] Police Report

Additional facility records:

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

Number of additional resident(s) reviewed: four

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:five

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

Attempts to contact:

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

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

Were contacts made with any of the following:

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

Observations were conducted related to:

- [x] Personal Care
- [x] Nursing Services
- [x] Call Light
- [x] Infection Control
- [x] Medication Pass
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Transfers
- [x] Meals
- [x] Facility Tour
- [x] Injury

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 - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Champlin Police Department

Champlin City Attorney

Hennepin County Attorney

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 30, 2018

Ms. Rhonda Schillinger, Administrator
Champlin GW LLC
11469 Jefferson Court North
Champlin, MN 55316

RE: Complaint Number HL25047002, HL25047003, and HL25047004

Dear Ms. Schillinger :

On January 12, 2018 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on September 1, 2017. At this time, these correction orders were found corrected.

You are encouraged to retain this document for your records. 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,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Hennepin County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H25047	A. BUILDING: _____ B. WING _____	C 09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPLIN GW LLC	11469 JEFFERSON COURT NORTH CHAMPLIN, MN 55316

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On July 13, 2017, a complaint investigation was initiated to investigate complaint #HL25047002, #HL25047003, and #HL25047004. At the time of the survey, there were 31 clients that were receiving services under the comprehensive license. The following correction orders are issued related to #HL25047002, #HL25047003, and #HL25047004 .	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 1441.474 subd. 11 (b) (1) (2)	
0 325 SS=E	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on document review, observations, and interview, the licensee failed to ensure that three of three clients (C1),(C2), and (C3) reviewed were free from maltreatment when the client was financially exploited by staff who took medications from the clients. This resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was no likely to cause serious injury, impairment, or death) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion of all of the client). The findings include: C1's record was reviewed. C1 was admitted to the facility on October 21, 2016 with a diagnosis of degenerative disc disease and received comprehensive home care services including medication management according to a service plan dated April 10, 2016. C1 had a prescription for oxycontin, dated February 2, 2017. C2's record was reviewed. C2 was admitted to the facility on January 16, 2015 with a diagnosis of memory loss and received comprehensive home care services including medication management according to a service plan dated April 4, 2017. C2 had a prescription for lorazepam .5 mg, dated March 29, 2017.	0 325		

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0 325	Continued From page 2 C3's record was reviewed. C3 was admitted to the facility on December 23, 2014 with a diagnosis of dementia and received comprehensive home care services including medication management according to a service plan dated April 4, 2017. C3 had a prescription for oxycodone 5mg that was refilled on April 27, 2017. Document review and interview on July 13, 2017 revealed C1 was missing 16 oxycontin tablets, C2 was missing 14 half tablets of lorazepam, and C3 was missing 30 oxycodone tablets. Document review revealed the facility received an oxycontin delivery for C1 on the evening of February 2, 2017 and it contained a staff signature by unlicensed personnel (ULP-F) on the evening of delivery, and a signature by licensed practical nurse (LPN-B) the next day, February 3, 2017. On February 3, 2017 LPN-B discovered that the client was missing 16 oxycontin tablets. The facility was unable to find when and where the tablets went missing as they were not counted in on delivery to the facililty. During an interview, LPN-B on July 13, 2017 at 3:07 p.m. said s/he came in one morning and there were a bunch of meds sitting in the nurse's office in bags, which was not normal. LPN-B states s/he is not sure where the medications went. During an interview, ULP-F on August 21, 2017 at 10:34 a.m. said that s/he did not remember the specific delivery referred to, but stated that when deliveries come in on the evening shift, s/he signs for them and puts them on the nursing desk and that sometimes it sits on the desk until the nurse	0 325		

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0 325	Continued From page 3 comes in the next morning. Observations on July 13, 2017 revealed the nursing office door to be left open on multiple occasions. No medications were seen on the nursing desk at the time of the on site investigation. During an interview, ULP-C on July 13, 2017 at 2:20 p.m. said that registered nurse (RN-H) admitted to taking a pack of ativan from C2 to him/her. ULP-C states that they are supposed to be double signing and counting off on narcotics at the end and beginning of each shift, but that it is not always being done by all staff. During an interview, ULP-D on July 13, 2017 at 3:40 p.m. said that RN-H admitted to taking a a full card of lorazepam tablets from C2 to him/her. During an interview, ULP-E on July 13, 2017 at 2:40 p.m. said that RN-H admitted to taking a seven full ativan tablets from C2 to him/her. ULP-E states that they are supposed to be signing off each shift on the narcotic count book, but that sometimes people forget. During an interview, house manager (HM-A) on July 13, 2017 at 4:47 p.m. said C1's medications were never found and she is unsure where those medications went. HM-A states multiple staff had brought forward concerns about registered nurse (RN-H) taking C2's lorazepam and on May 26, 2017 RN-H admitted to taking the narcotics to him/her and his/her employment was terminated. HM-A states that after RN-H's employement was terminated they discovered C3 to be missing oxycodone, s/he assumed RN-H had taken the medication as s/he was the only person to have the key to the back stock medication at the time.	0 325		

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0 325	Continued From page 4 During an interview, RN-H on July 14, 2017 at 12:00 pm. said that s/he took C2's ativan for his/her spouse who had a prescription for the medication because s/he was unable to make it to the pharmacy before it closed. RN-H stated that s/he did not take C3's medication on initial phone interview, however in an email dated July 22, 2017 at 12:37 p.m. RN-H admitted to taking medications from other clients, but did not state what medications s/he took, who the medications were taken from, or when the medications were taken. The email stated that RN-H wasn't sure if they were the client's medications that were mentioned during the interview, but said that it could have been. On a document the facility stated they used as a controlled drug shift sign off sheet, there are directions that indicate, "controlled drugs MUST be counted and signed by both staff members prior to handing keys to on-coming shift". Each day has two signatures required for the AM shift, two signatures required for the PM shift, and two signatures required for the NOC shift, for a total of six signatures required each day. February was reviewed, because this was the date of the first incident of missing medications. From February 1, 2017 through February 28, 2017 there were 33 blank signature spots. June was reviewed, because this was the month after all three incidents of missing medication had been discovered. From June 1, 2017 to June 30, 2017 there were 67 blank signature spots. According to policy titled, "Handling of Client's finances and property", dated November 14, 2016, indicated that staff may not borrow a client's funds or personal or real property nor in any way convert a client's property to the	0 325		

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0 325	Continued From page 5 agency's or staff's possession. According to facility policy titled, "Controlled substances/Schedule II drugs, dated January 27, 2016, indicates that home care staff, including a licensed nurse whenever possible, will count controlled drugs at the end of each shift. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the nurse. Delivery of controlled substance: when the pharmacy delivers a prescribed controlled substance medication for a client, the licensed nurse or medication passer will count the medication and will attest, by signing their full name that the correct amount of medication has been delivered. If the count is inconsistent with the prescription label, the recipient will immediately call the pharmacy and will not accept delivery of the prescription. The licensed nurse accepting the delivery will put the controlled medications in a locked compartment separate from containers for non-controlled medications and log it into the controlled substance count book. If the nurse is not available the medication passer will verify the count with an additional staff person, place the medications in the locked compartment separate from containers for non-controlled medications and log it into the controlled substance count book. Both employees are to sign their full name in the book to attest to receipt. This agency will take all reasonable precautions to eliminate the theft, diversion or misuse of controlled substances and will comply with requirement regarding the safe storage and disposal of these drugs. According to facility policy, dated October 30, 2015 and titled "Narcotic Count", indicates that it	0 325		

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0 325	Continued From page 6 is the policy of White Pine/Gracewood Senior Living that all controlled substances Schedule II-IV be counted at the beginning and end of every shift. Employees are to sign and date that this has been completed. TIME PERIOD OF CORRECTION: Twenty One (21) days	0 325		
0 900 SS=F	144A.4792, Subd. 1 Medication Management; Comprehensive Subdivision 1. Medication management services; comprehensive home care license. (a) This subdivision applies only to home care providers with a comprehensive home care license that provide medication management services to clients. Medication management services may not be provided by a home care provider who has a basic home care license. (b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications;	0 900		

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0 900	Continued From page 7 verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to implement policies and procedures that ensure the security and accountability for controlled medications that the licensee managed for three of three clients (C1), (C2), and (C3) reviewed. This resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was no likely to cause serious injury, impairment, or death) and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion of all	0 900		

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0 900	Continued From page 8 of the client). The findings include: C1's record was reviewed. C1 was admitted to the facility on October 21, 2016 with a diagnosis of degenerative disc disease and received comprehensive home care services including medication management according to a service plan dated April 10, 2016. C1 had a prescription for oxycontin, dated February 2, 2017. C2's record was reviewed. C2 was admitted to the facility on January 16, 2015 with a diagnosis of memory loss and received comprehensive home care services including medication management according to a service plan dated April 4, 2017. C2 had a prescription for lorazepam .5 mg, dated March 29, 2017. C3's record was reviewed. C3 was admitted to the facility on December 23, 2014 with a diagnosis of dementia and received comprehensive home care services including medication management according to a service plan dated April 4, 2017. C3 had a prescription for oxycodone 5mg that was refilled on April 27, 2017. Document review and interview on July 13, 2017 revealed C1 was missing 16 oxycontin tablets, C2 was missing 14 half tablets of lorazepam, and C3 was missing 30 oxycodone tablets. Document review revealed the facility received an oxycontin delivery for C1 on the evening of February 2, 2017 and it contained a staff signature by unlicensed personnel (ULP-F) on the evening of delivery, and a signature by licensed practical nurse (LPN-B) on the next day, February 3, 2017. On February 3, 2017 it was discovered that the client was missing 16 oxycontin tablets by	0 900		

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	H25047	A. BUILDING: _____ B. WING _____	C 09/01/2017

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0 900	Continued From page 9 LPN-B. The facility was unable to find when and where the tablets went missing as they were not counted in on delivery to the facililty. During an interview, LPN-B on July 13, 2017 at 3:07 p.m. said s/he came in one morning and there were a bunch of meds sitting in the nurse's office in bags, which was not normal. LPN-B states s/he is not sure where the medications went. During an interview, ULP-F on August 21, 2017 at 10:34 a.m. said that s/he did not remember the specific delivery referred to, but stated that when deliveries come in on the evening shift, s/he signs for them and puts them on the nursing desk and that sometimes it sits on the desk until the nurse comes in the next morning. Observations on July 13, 2017 revealed the nursing office door to be left open on multiple occasions. No medications were seen on the nursing desk at the time of the on site investigation. During an interview, ULP-C on July 13, 2017 at 2:20 p.m. said that registered nurse (RN-H) admitted to taking a pack of ativan from C2 to him/her. ULP-C states that they are supposed to be double signing and counting off on narcotics at the end and beginning of each shift, but that it is not always being done by all staff. During an interview, ULP-D on July 13, 2017 at 3:40 p.m. said that RN-H admitted to taking a a full card of lorazepam tablets from C2 to him/her. During an interview, ULP-E on July 13, 2017 at 2:40 p.m. said that RN-H admitted to taking a seven full ativan tablets from C2 to him/her.	0 900		

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0 900	Continued From page 10 ULP-E states that they are supposed to be signing off each shift on the narcotic count book, but that sometimes people forget. During an interview, house manager (HM-A) on July 13, 2017 at 4:47 p.m. said C1's medications were never found and she is unsure where those medications went. HM-A states multiple staff had brought forward concerns about registered nurse (RN-H) taking C2's lorazepam and on May 26, 2017 RN-H admitted to taking the narcotics and his/her employment was terminated. HM-A states that after RN-H's employement was terminated they discovered C3 to be missing oxycodone, s/he assumed RN-H had taken the medication as s/he was the only person to have the key to the back stock medication at the time. During an interview, RN-H on July 14, 2017 at 12:00 pm. said that s/he took C2's ativan for his/her spouse who had a prescription for the medication because s/he was unable to make it to the pharmacy before it closed. RN-H stated that s/he did not take C3's medication on initial phone interview, however in an email dated July 22, 2017 at 12:37 p.m. RN-H admitted to taking medications from other clients, but did not state what medications s/he took, who the medications were taken from, or when the medications were taken. The email stated that RN-H wasn't sure if they were the client's medications that were mentioned during the interview, but said that it could have been. On a document the facility stated they used as a controlled drug shift sign off sheet, there are directions that indicate, "controlled drugs MUST be counted and signed by both staff members prior to handing keys to on-coming shift". Each day has two signatures required for the AM shift,	0 900		

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0 900	Continued From page 11 two signatures required for the PM shift, and two signatures required for the NOC shift, for a total of six signatures required each day. February was reviewed, because this was the date of the first incident of missing medications. From February 1, 2017 through February 28, 2017 there were 33 blank signature spots. June was reviewed, because this was the month after all three incidents of missing medication had been discovered. From June 1, 2017 to June 30, 2017 there were 67 blank signature spots. According to policy titled, "Handling of Client's finances and property", dated November 14, 2016, indicated that staff may not borrow a client's funds or personal or real property nor in any way convert a client's property to the agency's or staff's possession. According to facility policy titled, "Controlled substances/Schedule II drugs, dated January 27, 2016, indicates that home care staff, including a licensed nurse whenever possible, will count controlled drugs at the end of each shift. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the nurse. Delivery of controlled substance: when the pharmacy delivers a prescribed controlled substance medication for a client, the licensed nurse or medication passer will count the medication and will attest, by signing their full name that the correct amount of medication has been delivered. If the count is inconsistent with the prescription label, the recipient will immediately call the pharmacy and will not accept delivery of the prescription. The licensed nurse accepting the delivery will put the controlled medications in a locked compartment separate	0 900		

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0 900	Continued From page 12 from containers for non-controlled medications and log it into the controlled substance count book. If the nurse is not available the medication passer will verify the count with an additional staff person, place the medications in the locked compartment separate from containers for non-controlled medications and log it into the controlled substance count book. Both employees are to sign their full name in the book to attest to receipt. This agency will take all reasonable precautions to eliminate the theft, diversion or misuse of controlled substances and will comply with requirement regarding the safe storage and disposal of these drugs. According to facility policy, dated October 30, 2015 and titled "Narcotic Count", indicates that it is the policy of White Pine/Gracewood Senior Living that all controlled substances Schedule II-IV be counted at the beginning and end of every shift. Employees are to sign and date that this has been completed. TIME PERIOD OF CORRECTION: Twenty One (21) days	0 900		