MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Meridian Manor			**Report Number:** HL29081003	**Date of Visit:** July 12 and 13, 2017
Facility Address: 163 West Wayzata Blvd.			**Time of Visit:** 8:30 a.m. to 3:30 p.m. and 12:00 p.m. to 2:30 p.m.	**Date Concluded:** September 14, 2017
Facility City: Wayzata			**Investigator's Name and Title:** Darin Hatch, Special Investigator	
State: Minnesota	**ZIP:** 55391	**County:** Hennepin		

☒ **Home Care Provider/Assisted Living**

Allegation(s):
It is alleged that nine clients were financially exploited when the alleged perpetrator (AP) took narcotic medications for his/her own personal use.

☒ 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:
Based on a preponderance of evidence, financial exploitation-drug diversion occurred when the alleged perpetrator (AP) took narcotic medications from nine clients between June 2016 and February 2017.

All nine client received comprehensive home care services from the provider for medication management and had physician's orders for narcotic medication's.

The alleged perpetrator (AP) told another staff member that the AP was getting good at forging the nurses signature on the medication destruction records and s/he had been destroying discontinued medication alone without the nurse. The staff member told a nurse. The nurse conducted an investigation and contacted police. Police interviewed the AP at the facilty. The AP admitted s/he took client's discontinued narcotic medications for personal use.

According to interviews with staff and document review, AP took : 101 tablets of clonazepam 0.5 milligrams (mg) from Client #1, 39 tablets of tramadol 50 mg from Client #2, 30 tablets of hydromorphone 2 mg and 30 tablets of tramadol 50 mg from Client #3, 18 tablets of oxycodone 5 mg and 58 tablets of methadone 5 mg from Client #4, 9 tablets of Oxycontin 10 mg from Client #5, 40 tablets of hydromorphone 2 mg and 29

ml of Dilaudid 5 milligrams/milliter (mg/ml) from Client #6, 147 tablets of hydromorphone 2 mg, 29 ml of lorazepam 2mg/ml liquid, 22.4 ml hydromorphone 5mg/ml liquid and 51 tablets of morphine 15 mg from Client #7, 25 tablets of Ativan 0.25 mg and 12 ml of morphine 100mg/5ml liquid of Client #8, and 250 ml of oxycodone 5mg/ml liquid and 29 ml of lorazepam 2mg/ml liquid from Client #9.

All of the medications had been discontinued and set for medication destruction. There was no evidence the AP had taken any medications from the medication carts where active prescriptions for clients were stored. There was no evidence any clients went without any medication.

During an interview, the nurse said the AP had forged his/her signature on the medication destruction records for nine clients' discontinued narcotics between June 2016 and February 2017.

A police report indicated the AP admitted s/he took all of the suspected diverted discontinued medication for his/her own personal use. Police forwarded their investigation findings to the county attorney for formal charges.

The AP declined an interview.

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 home care provider had policies in place to prevent financial exploitation. The AP's personnel file showed the AP's acknowledgment of receiving the "Employee Handbook" which indicated any theft was unacceptable in the workplace and was grounds for involuntary termination. The AP's personnel file showed the AP received training in regards to the policies in place. The facility was also responsible as the provider failed to implement it's own policy to prevent diversion of medication when they failed to provide adequate supervision of the AP and the medication destruction process.

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:

(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] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] ADL (Activities of Daily Living) Flow Sheets
- [x] Service Plan
- [x] Other, specify: Physician's orders

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
- [x] Other, specify: court records

Number of additional resident(s) reviewed: None

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

Specify: No additional records were selected

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: Seven

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Nine

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

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

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:

☒ Use of Equipment
☒ Medication Pass
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Meals
☒ Facility Tour
☒ Other: Medication Storage

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

Minnesota Board of Pharmacy

The Office of Ombudsman for Long-Term Care

Wayzata Police Department

Hennepin County Attorney

Wayzata City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29081	A. BUILDING: _____ B. WING _____	C 08/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN MANOR	163 WEST WAYZATA BOULEVARD WAYZATA, MN 55391

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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, these correction orders are 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 12, 2017, a complaint investigation was initiated to investigate complaint #HL29081003. At the time of the survey, there were 35 clients that were receiving services under the comprehensive license. The following correction orders are issued.	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=F	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 and interview, the licensee failed to ensure the right of nine of nine clients, (C1, C2, C3, C4, C5, C6, C7, C8, and C9), reviewed were free from maltreatment-financial exploitation-drug diversion when a nurse diverted medications set for destruction for her own personal use. The violation occurred as a level 2 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 not 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 or all of the clients.) The findings include: C1's file was reviewed. C1 received medication management from the licensee according to a service agreement dated May 29, 2015. C1 had a physician's order for clonazepam (an anti-anxiety medication) 0.5 milligrams (mg) dated April 22, 2016 and May 10-16. Document destruction records indicated 101 tablets of clonazepam were discontinued on June 10, June 13, and August 30, 2016. C2's file was reviewed. C2 received medication management from the licensee according to a	0 325		

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0 325	Continued From page 2 service agreement dated May 29, 2015. C2 had a physician's order for tramadol (a synthetic pain reliever) 50 mg dated March 26 and June 8, 2016. Document destruction records indicated 39 tablets tramadol were discontinued on June 24 and July 5, 2016. C3's file was reviewed. C3 received medication management from the licensee according to a service agreement dated April 10, 2016. C3 had a physician's order for tramadol (a synthetic pain reliever) 50 mg dated June 3 and 15, 2016 and for hydromorphone (an opioid pain reliever) 2 mg dated April 19 and May 27, 2016. Document destruction records indicated 30 tablets of tramadol were discontinued on June 30 and August 9, 2016 and 30 tablets of hydromorphone were discontinued on June 30, 2016. C4's file was reviewed. C4 received medication management from the licensee according to a service agreement dated February 10, 2015. C4 had a physician's order for oxycodone (an opioid pain reliever) 5 mg dated April 19, 2016 and for methadone (an opioid pain reliever) 5 mg dated June 7, 2016. Document destruction records indicated 18 tablets of oxycodone and 58 tablets of methadone were discontinued on August 11, 2016. C5's file was reviewed. C5 received medication management from the licensee according to a service agreement dated October 12, 2016. C5 had a physician's order for Oxycontin (an opioid pain reliever) 10 mg dated August 22, 2016. Document destruction records indicated 9 tablets of Oxycontin were discontinued on August 23, 2016. C6's file was reviewed. C6 received medication	0 325		

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0 325	Continued From page 3 management from the licensee according to a service agreement dated July 15, 2016. C6 had a physician's order for hydromorphone (an opioid pain reliever) 2 mg dated August 15, 2016 and hydromorphone 5 mg/ml (milliliters) dated September 5, 2016. Document destruction records indicated 40 tablets of hydromorphone 2 mg tablets were discontinued on on September 5, 2016 and 29 ml of hydromorphone 5 mg/ml was discontinued on September 15, 2016. C7's file was reviewed. C7 received medication management from the licensee according to a service agreement dated November 10, 2016. C7 had a physician's order for hydromorphone (an opioid pain reliever) 2 mg, lorazepam (an anti-anxiety medication) 2 mg/ml, hydromorphone 5 mg/ml, and morphine (an opioid pain reliever) 15 mg all dated November 10, 2016. Document destruction records indicated 147 tablets of 2 mg hydromorphone was discontinued on November 18, 2016. Document destruction records also indicated 29 ml of lorazepam was discontinued on November 18, 2016 along with 22.4 ml of hydromorphone and 51 tablets of morphine. C8's file was reviewed. C8 received medication management from the licensee according to a service agreement dated January 4, 2017. C8 had a physician's order for Ativan (an anti-anxiety medication) 0.25 mg dated January 24, 2017 and a physician's order for morphine (an opioid pain reliever) 100 mg/5 ml dated January 10, 2017. Document destruction records indicated 25 tablets of Ativan and 12 ml of morphine were discontinued on January 15, 2017. C9's file was reviewed. C9 received medication management from the licensee according to a service agreement dated January 12, 2017. C9	0 325		

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0 325	Continued From page 4 had a physician's order for oxycodone (an opioid pain reliever) 5 mg/ml dated January 30 and February 5, 2017 and a physician's order for lorazepam (an anti-anxiety medication) 2 mg/ml dated January 24, 2017. Document destruction records indicated 250 ml of oxycodone and 29 ml of lorazepam were discontinued on February 10, 2017. Interview with executive director (ED)-C on July 12, 2017 at 11:41 a.m. revealed ED-C said licensed practical nurse (LPN)-O was taking discontinued medication and allegedly destroying by herself without RN supervision but diverted and forged the RN's signature to the medication destruction records. ED-C said she interviewed LPN-O and LPN-O admitted to taking medications from C1-C9 for her own personal use. ED-C reviewed medication documents which indicated LPN-O diverted the following medication from C1 to C9 between June and February: C1-clonazepam 0.5 milligrams (mg)-101 tablets C2-tramadol 50 mg-39 tablets C3-hydromorphone 2 mg-30 tablets & tramadol 50 mg-30 tablets C4-oxycodone 5 mg- 18 tablets & methadone 5 mg-58 tablets C5-Oxycontin 10 mg- 9 tablets C6-hydromorphone 2 mg- 40 tablets & hydromorphone 5 mg/milliliters (ml) -29 ml of liquid C7-hydromorphone 2 mg- 147 tablets, lorazepam 2 mg/mL- 29 ml of liquid, hydromorphone 5 mg/ml- 22.4 ml of liquid, & morphine 15 mg- 51 tablets C8-Ativan 0.25 mg- 25 tablets & morphine 10mg/ml -12 ml of liquid C9-oxycodone 5 mg/ml- 250 ml of liquid &	0 325		

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0 325	Continued From page 5 lorazepam 2 mg/ml- 29 ml of liquid A police report dated February 24, 2017 indicated police were called to the facility on report of suspected drug diversion. Police reviewed documents, interviewed staff, and interviewed LPN-O. LPN-O admitted to police she took the suspected medications for her own personal use. Police referred their investigation findings to the county attorney for formal charges of felony controlled substance possession and theft. A court document dated April 17, 2017 indicated LPN-O was formally charged with felony controlled substance possession and theft. An untitled and undated document signed by LPN-O indicated she took the drugs for herself and would sign the registered nurse's name on the document destruction records. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 815 SS=D	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration,	0 815		

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0 815	Continued From page 6 or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to maintain documentation of annual performance reviews for LPN-O. The	0 815		

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0 815	Continued From page 7 violation occurred as a level 2 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 not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: LPN-O's file was reviewed. LPN-O had a date of hire of March 11, 2014. No performance evaluations were provided when requested during the onsite investigation. An e-mail dated July 17, 2017 at 10:21 a.m. from executive director (ED)-C indicated no annual performance review was able to be located by the licensee in the employee file. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 815		
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.	0 900		

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0 900	Continued From page 8 (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; 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.	0 900		

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0 900	Continued From page 9 This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to implement medication management services to ensure security and accountability for control substances it managed for nine of nine clients, (C1, C2, C3, C4, C5, C6, C7, C8, and C9), reviewed when a nurse diverted medications set for destruction for her own personal use. The violation occurred as a level 2 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 not 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 or all of the clients.) The findings include: C1's file was reviewed. C1 received medication management from the licensee according to a service agreement dated May 29, 2015. C1 had a physician's order for clonazepam (an anti-anxiety medication) 0.5 milligrams (mg) dated April 22, 2016 and May 10-16. Document destruction records indicated 101 tablets of clonazepam were discontinued on June 10, June 13, and August 30, 2016. C2's file was reviewed. C2 received medication management from the licensee according to a service agreement dated May 29, 2015. C2 had a physician's order for tramadol (a synthetic pain reliever) 50 mg dated March 26 and June 8, 2016. Document destruction records indicated 39 tablets tramadol were discontinued on June 24	0 900		

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	H29081	A. BUILDING: _____ B. WING _____	C 08/14/2017

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0 900	Continued From page 10 and July 5, 2016. C3's file was reviewed. C3 received medication management from the licensee according to a service agreement dated April 10, 2016. C3 had a physician's order for tramadol (a synthetic pain reliever) 50 mg dated June 3 and 15, 2016 and for hydromorphone (an opioid pain reliever) 2 mg dated April 19 and May 27, 2016. Document destruction records indicated 30 tablets of tramadol were discontinued on June 30 and August 9, 2016 and 30 tablets of hydromorphone were discontinued on June 30, 2016. C4's file was reviewed. C4 received medication management from the licensee according to a service agreement dated February 10, 2015. C4 had a physician's order for oxycodone (an opioid pain reliever) 5 mg dated April 19, 2016 and for methadone (an opioid pain reliever) 5 mg dated June 7, 2016. Document destruction records indicated 18 tablets of oxycodone and 58 tablets of methadone were discontinued on August 11, 2016. C5's file was reviewed. C5 received medication management from the licensee according to a service agreement dated October 12, 2016. C5 had a physician's order for Oxycontin (an opioid pain reliever) 10 mg dated August 22, 2016. Document destruction records indicated 9 tablets of Oxycontin were discontinued on August 23, 2016. C6's file was reviewed. C6 received medication management from the licensee according to a service agreement dated July 15, 2016. C6 had a physician's order for hydromorphone (an opioid pain reliever) 2 mg dated August 15, 2016 and hydromorphone 5 mg/ml (milliliters) dated	0 900		

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0 900	Continued From page 11 September 5, 2016. Document destruction records indicated 40 tablets of hydromorphone 2 mg tablets were discontinued on on September 5, 2016 and 29 ml of hydromorphone 5 mg/ml was discontinued on September 15, 2016. C7's file was reviewed. C7 received medication management from the licensee according to a service agreement dated November 10, 2016. C7 had a physician's order for hydromorphone (an opioid pain reliever) 2 mg, lorazepam (an anti-anxiety medication) 2 mg/ml, hydromorphone 5 mg/ml, and morphine (an opioid pain reliever) 15 mg all dated November 10, 2016. Document destruction records indicated 147 tablets of 2 mg hydromorphone was discontinued on November 18, 2016. Document destruction records also indicated 29 ml of lorazepam was discontinued on November 18, 2016 along with 22.4 ml of hydromorphone and 51 tablets of morphine. C8's file was reviewed. C8 received medication management from the licensee according to a service agreement dated January 4, 2017. C8 had a physician's order for Ativan (an anti-anxiety medication) 0.25 mg dated January 24, 2017 and a physician's order for morphine (an opioid pain reliever) 100 mg/5 ml dated January 10, 2017. Document destruction records indicated 25 tablets of Ativan and 12 ml of morphine were discontinued on January 15, 2017. C9's file was reviewed. C9 received medication management from the licensee according to a service agreement dated January 12, 2017. C9 had a physician's order for oxycodone (an opioid pain reliever) 5 mg/ml dated January 30 and February 5, 2017 and a physician's order for lorazepam (an anti-anxiety medication) 2 mg/ml dated January 24, 2017. Document destruction	0 900		

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0 900	Continued From page 12 records indicated 250 ml of oxycodone and 29 ml of lorazepam were discontinued on February 10, 2017. Interview with executive director (ED)-C on July 12, 2017 at 11:41 a.m. revealed ED-C said licensed practical nurse (LPN)-O was taking discontinued medication and allegedly destroying by herself without RN supervision but diverted and forged the RN's signature to the medication destruction records. ED-C said she interviewed LPN-O and LPN-O admitted to taking medications from C1-C9 for her own personal use. ED-C reviewed medication documents which indicated LPN-O diverted the following medication from C1 to C9 between June and February: C1-clonazepam 0.5 milligrams (mg)-101 tablets C2-tramadol 50 mg-39 tablets C3-hydromorphone 2 mg-30 tablets & tramadol 50 mg-30 tablets C4-oxycodone 5 mg- 18 tablets & methadone 5 mg-58 tablets C5-Oxycontin 10 mg- 9 tablets C6-hydromorphone 2 mg- 40 tablets & hydromorphone 5 mg/milliliters (ml) -29 ml of liquid C7-hydromorphone 2 mg- 147 tablets, lorazepam 2 mg/mL- 29 ml of liquid, hydromorphone 5 mg/ml- 22.4 ml of liquid, & morphine 15 mg- 51 tablets C8-Ativan 0.25 mg- 25 tablets & morphine 10mg/ml -12 ml of liquid C9-oxycodone 5 mg/ml- 250 ml of liquid & lorazepam 2 mg/ml- 29 ml of liquid A police report dated February 24, 2017 indicated police were called to the facility on report of suspected drug diversion. Police reviewed	0 900		

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0 900	Continued From page 13 documents, interviewed staff, and interviewed LPN-O. LPN-O admitted to police she took the suspected medications for her owne personal use. Police referred their investigation findings to the county attorney for formal charges of felony controlled substance possession and theft. A court document dated April 17, 2017 indicated LPN-O was formally charged with felony controlled substance possession and theft. An untitled and undated document signed by LPN-O indicated she took the drugs for herself and would sign the registered nurses name on the document destruction records.. A policy titled "Storage of Medications" and dated December 29, 2016 indicates medications managed by the home care provider shall be stored to prevent diversion. TIME PERIOD FOR CORRECTION Twenty-one (21) days	0 900		