Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL301333543M
Compliance #: HL301333847C

Date Concluded: August 1, 2024

Name, Address, and County of Licensee Investigated:
Augustana Apartments of Minneapolis
1509 10th Ave South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff member, financially exploited the resident when the AP took a resident's narcotic medication for personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Although the resident was missing six Oxycodone (narcotic pain medication) tablets, facility staff inconsistently reconciled the narcotic medication between every shift, therefore the facility could not identify a specific AP responsible for the missing Oxycodone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident and the resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, facility narcotic records, personnel files, staff schedules,

and related facility policy and procedures. Also, the investigator observed the resident and toured the facility.

The resident resided in an assisted living facility. The resident's diagnoses included a fractured femur (thigh bone), thoracic (middle section of spine) compression fracture, and lumbar (lower section of spine) compression fracture. The resident's service plan included assistance with medication administration. The resident was alert and oriented. The resident's medication assessment indicated the resident's narcotics were to be kept in a locked drawer of a locked medication cart.

The facility's incident report indicated one day the AP notified the nurse of six missing tablets of the resident's Oxycodone. The nurse verified the six missing doses of Oxycodone.

The facility's narcotic logbook indicated no staff had signed out any Oxycodone from the resident's narcotic medication card.

The facility's shift-to-shift count log lacked consistent reconciliation of the narcotics by the facility staff members.

During an interview, leadership stated when a narcotic was given to a resident, staff members would compare the narcotic medication card to the order in the computer. If the order was correct, the removal of the narcotic would be documented in the narcotic logbook. The narcotic would be removed from the narcotic medication card and documented as setup in the computer. The narcotic would be given to the resident and documented in the computer as completed. Leadership stated the expectation was that staff completed a shift-to-shift narcotic count on each medication cart.

During an interview, a facility nurse stated the AP notified the nurse of the resident's six missing Oxycodone tablets. The facility nurse stated the facility's system for counting narcotics between every shift was not consistently followed.

During an interview, nursing leadership stated at the time of the incident, shift-to-shift narcotic counting was not completed consistently. Nursing leadership stated because narcotic medication reconciliation had not been consistently completed every shift according to policy, it could not be determined when the resident's Oxycodone tablets went missing.

During an interview, the AP stated when narcotics were administered to residents there was a narcotic logbook that had a total amount of tablets remaining of the resident's narcotic medication card. The narcotic would be removed from the narcotic medication card and the number of narcotic tablets that remained in the narcotic medication card would be documented in the logbook. The AP stated one day, the resident had a fall, and it was reported by another staff member the resident requested medication for pain. The AP stated she did not follow the procedure when she attempted to give an Oxycodone to the resident. The AP stated

instead, she signed out the Oxycodone for the resident but skipped signing the medication out of the narcotic logbook. When returning to the narcotic logbook to document, the AP realized no staff had signed out any narcotics for the resident and six tablets were missing. The AP stated she notified the facility nurse of the resident's missing Oxycodone. The AP denied taking the resident's Oxycodone. The AP stated shift to shift counting to ensure the narcotics were accounted for was not being completed by facility staff.

In conclusion, the Minnesota Department of Health determined financial exploitation was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"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;
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Education was provided to facility staff about shift-to-shift narcotic counting.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MINNEAPOLIS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL301333543M/#HL301333847C On July 8, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 104 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL301333543M/#HL301333847C, tag identification 1920.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 evaluators' 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 144G.31 SUBDIVISION 1-3.	
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 1 management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed follow their procedure to prevent loss or spillage of controlled substances and medications for one of one (R1) resident reviewed for missing medications. This had the potential to affect all residents requiring the licensee to store and manage their medications.. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was 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 residents). The findings include:	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 2 R1's face sheet indicated R1 admitted to the licensee on April 2, 2024, with diagnoses of fractured femur (thigh bone), thoracic (middle back) compression fracture, and lumbar (lower back) compression fracture. R1's individualized medication management plan dated April 14, 2024, indicated R1's narcotic medications were stored in a locked drawer of a locked medication cart. The remainder of R1's non-narcotic medications were stored in the locked medication cart. In addition, R1's assessment indicated staff were directed to update a nurse with any concerns related to medication diversion and that a diversion would be investigated according to the licensee's policy. A progress note dated April 2, 2024, indicated licensed practical nurse (LPN)-F had received 200 tablets of medications for R1 from the pharmacy. LPN-F logged 28 doses of Oxycodone for R1 in a narcotic logbook and locked the Oxycodone in the medication cart. A brown stapled bag with the remaining medications was placed under the nurse's desk for an emergency. When LPN-F returned to the desk, the brown stapled bag was missing. A staff member stated she thought the bag was trash and threw the bag down the chute to the garbage. The garbage was searched by LPN-F and a housekeeper, but the bag could not be found. The director of nursing was called, and a voice mail was left. A pharmacy packing slip dated April 2, 2024, indicated that day, R1 received from the pharmacy: 176 acetaminophen tablets, 29 aspirin tablets, 29 atorvastatin (high cholesterol) tablets, 58 carvedilol (blood pressure) tablets, 29 lisinopril (blood pressure) tablets, 30 Oxycodone tablets,	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 3 and 58 senexon (constipation) tablets. The licensee's narcotic logbook indicated LPN-F had documented 28 doses of R1's Oxycodone were received from the pharmacy on April 2, 2024, instead of the 30 Oxycodone pills that were actually delivered to the licensee. The licensee's internal investigation dated April 4, 2024, indicated LPN-F received R1's medications. The medications were left under a desk in the nurse's station. Unlicensed personnel (ULP)-I was cleaning the nurse station and threw the bag in a chute that led to the garbage. The internal investigation indicated staff searched that garbage and did not find the medications. The internal investigation indicated LPN-F and ULP-I were trusted employees and that LPN-F failed to secure medications in the medication cart appropriately. LPN-F was written up to prevent a similar incident, was provided a copy of the licensee's policy for controlled substances management and monitored for compliance with narcotic storage. R1's April, 2024, medication administration record (MAR) indicated R1 had an order for Oxycodone tablet 5 mg, 1/2 tablet (2.5 mg) by mouth every four hours as needed for pain. R1's April 2024, MAR indicated no staff administered Oxycodone to R1. The licensee's internal investigation dated May 2, 2024, indicated ULP-E brought R1's Oxycodone card to LPN-F after noticing six Oxycodone were missing from R1's narcotic card. As a result of the investigation a narcotic logbook was started and signed by staff during change of shift. R1's May 2024, MAR indicated R1 had an order	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 4 for Oxycodone tablet 5 mg, 1/2 tablet (2.5 mg) by mouth every four hours as needed for pain. R1's May 2024, MAR indicated only one staff member, ULP-E administered one dose of Oxycodone to R1 on May 2, 2024, at 9:30 p.m. R1's Oxycodone order was discontinued on May 19, 2024. The licensee's second floor narcotic logbook reviewed for May 2024, and June 2024, indicated three times a day staff were directed to reconcile narcotic medications at change of shift morning, evening and overnight The following omission were noted in R1's narcotic logbook. - May 1, 2024, through May 12, 2024, the narcotic logbook lacked documentation of staff signatures to ensure narcotic count was completed. - May 14, 2024, the narcotic logbook was missing signatures for the evening and overnight count. - May 15, 2024, the narcotic logbook was missing signatures for day shift count. - May 16, 2024, the narcotic logbook was missing signatures for overnight count. - May 18, 2024, the narcotic logbook was missing signatures for both evening and overnight count. - May 19 through May 23, 22024, the narcotic logbook lacked signatures that a narcotic count was completed for four days. - May 24, 2024, the narcotic logbook was missing signatures for overnight count. - May 25, 2024, the narcotic logbook was missing signatures for both evening and overnight count. - May 29, 2024, the narcotic logbook was missing signatures for evening count. - June 4, 2024, the narcotic logbook was missing signatures for both evening and overnight count.	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 5 - June 8, 2024, the narcotic logbook was missing signatures for overnight count. - June 11, 2024, the narcotic logbook was missing signatures for evening count. - June 13, 2024, the narcotic logbook was missing signatures for day count. - June 16, 2024, the narcotic logbook was missing signatures for both day and evening count. - June 17, 2024, the narcotic logbook was missing signatures for evening count. - June 24, 2024, the narcotic logbook was missing signatures for overnight count. - June 27, 2024, the narcotic logbook was missing signatures for evening count. During an interview on July 8, 2024, at 9:50 a.m., R1 stated she did not take Oxycodone for pain and had requested the facility to stop giving it to her. During an interview on July 8, 2024, at 12:53 p.m., regional nurse-C (RN)-C and licensed assisted living director (LALD)-D indicated the licensee's expectation was staff complete a count of the narcotic medications with two staff at the end of one shift and the beginning of the second staff's shift. During an interview on July 9, 2024, at 12:04 p.m. ULP-E stated when a narcotic is taken from the resident's narcotic card, the tablet must be documented in the narcotic logbook to indicate how many tablets remain in the narcotic card. ULP-E stated staff did not do shift to shift narcotic counts, and often staff would just start their shift and begin passing medications to residents. ULP-E stated one evening, R1 had a fall and requested something for pain. ULP-E stated when R1's Oxycodone was removed from the	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 6 card, the card was observed to have six tablets of Oxycodone missing even though no one had signed medication out in the narcotic logbook. ULP-E brought R1's narcotic card to LPN-F. ULP-E denied taking R1's Oxycodone. During an interview on July 10, 2024, at 3:01 p.m. LPN-F stated when a narcotic medication comes from the pharmacy, the nurse is to document the controlled medication in the narcotic logbook, lock the medication in the locked drawer of the medication cart, and lock the medication cart. LPN-F stated staff were expected to count the narcotics at shift change but that did not happen consistently. LPN-F stated on April 2, 2024, after locking R1's Oxycodone in the medication cart, she was called away for an emergency. Instead of securing R1 other medications, LPN-F left the area placing R1's remaining medications in a brown bag unsecured under a desk. LPN-F stated "I should have locked them up." LPN-F stated when she returned to the nurse station, the bag was gone, and ULP-I stated she threw the bag in the garbage. In addition, LPN-F stated on May 2, 2024, ULP-E brought R1's Oxycodone card to the nurse station with six tablets of Oxycodone missing from the card and no staff had documented giving the medication to R1. LPN-F stated an incident report was filled out and given to the director of nursing. During a follow up interview on July 10, 2024, at 11:00 a.m. RN-C stated when R1's Oxycodone was delivered from the pharmacy on April 2, 2024, LPN-F did not look at R1's Oxycodone card close enough and assumed they had received 28 tablets instead of the 30 tablets received. RN-C also stated when narcotic medications were missing, staff must notify a nurse onsite or an on-call nurse. The licensee would initiate an	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30133	A. BUILDING: _____ B. WING _____	C 07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 7 investigation and attempt to find the missing medications. If the medications cannot be found, law enforcement and the Minnesota Department of Health would be notified. RN-C stated if the shift to shift counting was not documented in the narcotic logbook, it must be assumed that the count was not completed. RN-C stated when staff complete the shift to shift narcotic counting consistently, during the investigation into missing medication, the facility could develop a timeframe of when the narcotic went missing and identify staff responsible. The licensee's Controlled Substance policy dated May 31, 2024, indicated the licensee will take all reasonable precautions to eliminate the theft or misuse of controlled substances and will comply with requirements regarding the safe storage and disposal of these drugs. The policy also indicated a nurse will count at random the narcotics in central storage, medication carts or cabinets at least weekly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		