

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2024
NAME OF PROVIDER OR SUPPLIER Woodlyn Heights Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2060 Upper 55th Street East Inver Grove Heights, MN 55077	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649</p> <p>Based on observation, interview, and record review the facility failed to have a system in place to record accurate narcotic reconciliation to be able to account for all controlled substances for a 1 of 3 residents (R1) reviewed. The facility failed to identify prompt identification of loss or potential diversion of a controlled medication or determine the extent of loss for thirty morphine tablets ordered for R1.</p> <p>Findings include:</p> <p>Upon observation on 3/4/24 at 2:35 p.m. a pharmacy receipt for R1's morphine delivery on 2/16/24 was not found in the facility receipt bin on the wall. The bin had a pile of receipts dated from 1/29/24 - 3/5/24.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 10 indicating cognitive impairment. R1 required moderate assistance of one staff member for dressing and hygiene. R1's pertinent diagnoses was metabolic encephalopathy (an imbalance of or reduced oxygen to the brain).</p> <p>R1's physician order dated 2/15/24 indicated R1 was admitted to Hospice. R1 was ordered morphine (a controlled narcotic medication for severe pain) 5 milligram (mg) solutab, give 1 tablet as needed for pain and air hunger.</p> <p>R1's nursing progress note dated 3/2/24 indicated R1 had passed away the facility.</p> <p>The facility narcotic logbook did not include R1's physician order dated 2/1/24 for morphine 5 mg 30 solutabs, give 1 tablet as needed for pain and air hunger.</p> <p>Upon interview on 3/4/24 at 10:11 a.m. a hospice registered nurse (RN)-A stated she visited R1 in the facility on 2/27/24 and asked the facility staff, RN-B to administer a morphine tablet to R1. RN-B told RN-A that R1 did not have any morphine. RN-A stated she called the pharmacy and was told the facility received the medication on 2/17/24 and was signed by licensed practical nurse (LPN)-A. The pharmacy used was not the facilities regular pharmacy, because the regular pharmacy did not dispense morphine solutabs.</p> <p>RN-B was unavailable for an interview at the time of the survey.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Upon interview on 3/4/24 at 10:30 a.m. the pharmacist stated on 2/16/24 she had record of morphine 5 mg 30 solutabs being delivered to the facility on [DATE] at 4:12 p.m. She stated the pharmacy used a third-party courier service for this delivery, so the actual driver was unknown by the pharmacy. She stated the third-party courier delivers the medications and then scans back to the pharmacy the date, time, and a staff signature.</p> <p>Upon interview on 3/4/24 at 11:51 a.m. LPN-A stated he does not ever work in the transitional care unit (TCU) where R1 resided. He stated he works on the upper level and does not sign-in medications for the units on the lower level. LPN-A stated the signature on the receipt was not his signature. During the interview LPN-A insisted upon signing his name to show the signature was not his.</p> <p>Upon interview on 3/4/24 at 1:12 p.m. RN-C stated he did not recall ever seeing a card of morphine 5 mg 30 solutabs for R1. RN-C stated that some of the nurses who work on the upper level of the facility will sign-in medications for the residents in the TCU, but he does not recall LPN-A ever delivering any medications to him. RN-C stated when a medication order is written by a provider, the nursing staff transcribes the order, by faxing the order to the pharmacy if it is needed, transcribes the order into point click care (PCC) the facilities software system and then another nurse signs off to make sure the order was correctly transcribed. RN-C stated the pharmacy usually delivers the medications around 9:00 p.m. on his shift and if there are any narcotics in the delivery, he records the medication in the narcotic logbook and puts the medication on the cart in the lock box. RN-C stated the receipts of medications are kept in a bin attached to the wall in the room where the charts are stored. RN-C did not know why the receipts were kept.</p> <p>Upon interview on 3/4/24 at 1:28 p.m. RN-D, nurse manager, stated he was not aware that the morphine was ordered and apparently received by the facility until 2/27/24 when the staff was looking for it. RN-D stated the facility would have caught the error if the medication were a scheduled medication because then staff would have had to administer it right away, but since it was PRN (as needed), it was not needed, therefor nobody noticed it was not at the facility. RN-D stated two staff members are required for completion of all orders, one nurse transcribes the order another staff verifies the order. RN-D denied having any procedures in place to make sure the ordered medications were received.</p> <p>Upon interview on 3/5/24 at 10:05 a.m. RN-D, regional nursing director stated she was involved in the investigation for R1. RN-D stated that upon facility interviews none of the nursing staff had seen the medication. She ordered the staff to check all medications carts for the morphine and any other medication narcotic discrepancies, which turned up no morphine and no other discrepancies. She stated when a medication is ordered the nurse is supposed to check that the medication is delivered or report off to the next shift that a medication is on the way. RN-D stated there is not a good system for in place for monitoring receipts.</p> <p>A facility policy titled Controlled Substances updated on 10/19/22 indicated under the title Receiving Controlled Substances: A: When the nurse receives the controlled the nurse will need to fill out the top portion of the controlled drug administration record. The bottom part where the residents name goes, and the first line on the section that counts the medication down. The reason the first line down needs to be filled out is to see who signed in the medication from the pharmacy. The policy does not indicate a process if medication is not received from the pharmacy.</p>		