

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	
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 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938</p> <p>Based on interview and document review, the facility failed to ensure 12 of 25 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12) reviewed for drug diversion were free from misappropriation of their property when their medications were taken by a staff member. This resulted in diversion of 121 oxycodone tablets, one tramadol tablet and two doses of liquid lorazepam.</p> <p>The immediate jeopardy (IJ) began on 9/27/24, when registered nurse (RN)-A notified the director of nursing (DON) with her concerns that trained medication aide (TMA-A) had been signing controlled medications out of the narcotic logbook. However, TMA-A was not documenting medication in the medication administration record (MAR) as given. R1 and R2 notified RN-A and their provider they had not received as needed (PRN) medications. The facility initiated an internal investigation, which included additional narcotic record review and audits against electronic medical records. Discrepancies were found in the following records: R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11 and R12. Records indicated narcotics were signed out in the narcotic logbook to indicate removal from the medication cart but were not signed in the MAR to indicate medication was administered. Facility suspended TMA-A while they conducted their investigation. TMA-A was subsequently terminated and the facility notified law enforcement. The administrator was notified of the IJ on 10/3/24 at 5:01 p.m. The facility had implemented immediate corrective action on 9/27/24 to prevent recurrence, therefore the IJ was issued at past non-compliance.</p> <p>Findings include:</p> <p>Review of the facility narcotic record indicated the following medications were signed out as removed from the medication cart, however, were not documented in the MAR as administered:</p> <p>R1 - 23 oxycodone tablets</p> <p>R2 - six oxycodone tablets</p> <p>R3 - 18 oxycodone tablets</p> <p>R4 - 12 oxycodone tablets</p> <p>R5 - 15 oxycodone tablets</p> <p>R6 - three oxycodone tablets</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 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7 - four oxycodone tablets</p> <p>R8 - 11 oxycodone tablets</p> <p>R9 - four oxycodone tablets and one tramadol tablet</p> <p>R10 - 20 oxycodone tablets</p> <p>R11 - four oxycodone tablets</p> <p>R12 - two doses of liquid lorazepam</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and diagnoses of acquired absence of right and left leg above knee, phantom limb syndrome with pain, muscles spasms, and unspecified pain.</p> <p>R1's Physician's Order Sheet printed on 10/1/24, indicated a physician order for oxycodone (an opioid medication used to treat moderate to severe pain) five milligrams (mg) by mouth every four hours as needed for moderate to severe pain with a pain rating of 7-10.</p> <p>R1's MAR indicated the controlled medication that was signed out of the narcotic log book by TMA-A, was not documented as administered in R1's electronic health record.</p> <p>R1's record indicated no negative outcomes occurred from not receiving the narcotic medications.</p> <p>R2's Minimum Data Set (MDS) entry tracking record indicated admitted [DATE], indicated moderate cognitive impairment, no disorganized thinking, no behavioral symptoms, upper extremity impairment on both sides, use of a wheelchair, and dependent on staff for eating, toilet use, dressing, and personal hygiene.</p> <p>R2's Physician's orders printed 10/1/24, indicated diagnoses of multiple fractures of ribs, anxiety, and amyotrophic lateral sclerosis (ALS).</p> <p>R2's pain assessment dated [DATE], indicated use of scheduled and as needed pain medications, frequent pain presence, and pain occasionally affecting sleep.</p> <p>R2's Medication Administration Record (MAR) printed 9/26/24, indicated physician's orders for scheduled acetaminophen and as needed oxycodone HCL five milligrams take one to two tablets by mouth every three hours (pain medication) as needed.</p> <p>R2's individual narcotic record indicated six doses of oxycodone were signed out of the log from 9/17/24 through 9/23/24.</p> <p>Facility MAR dated 9/1/24 through 9/30/24, indicated three doses of oxycodone administered during R2's stay.</p> <p>Facility investigation pain interview dated 9/25/24, indicated R2 reported pain managed well with acetaminophen and adamant about only taking one dose of oxycodone while at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R6's MAR indicated the controlled medication that was signed out of the narcotic log book by TMA-A was not documented as administered in R6's electronic health record.</p> <p>R6's record indicated no negative outcomes occurred from not receiving the narcotic medications.</p> <p>R7's quarterly MDS dated [DATE], identified R7 had intact cognition and diagnoses of chronic pain syndrome, major depressive disorder, low back pain, osteoarthritis, anxiety disorder and muscle spasms of the back.</p> <p>R7's Physician's Order Sheet printed on 10/3/24, indicated a physician order for oxycodone five mg - give two and a half mg by mouth as needed for moderate to severe pain.</p> <p>R7's MAR indicated the controlled medication that was signed out of the narcotic log book by TMA-A was not documented as administered in R7's electronic health record.</p> <p>R7's record indicated no negative outcomes occurred from not receiving the narcotic medications.</p> <p>R8's quarterly MDS dated [DATE], indicated intact cognition, scheduled and as needed pain medications, occasional pain that did not affect sleep, therapy, or daily activities.</p> <p>R8's Physician's orders printed 10/2/24, indicated diagnoses of chronic pain syndrome, left hip pain, and disc degeneration causing back pain. Medication order for pain management was oxycodone five milligram tablet take one tablet every six hours as needed for pain.</p> <p>Review of MAR and individual narcotic record dated from 5/1/24 through 8/31/24, indicated 11 doses of oxycodone five milligram tablets were signed out on the individual narcotic record but were not documented on the MAR as administered to R8.</p> <p>R8 no longer resided in the facility and did not respond to phone call for interview.</p> <p>R9's significant change MDS dated [DATE], indicated intact cognition, diagnoses of fracture of first and second cervical vertebra with routine healing, wedge compression fracture of fourth thoracic vertebra with routine healing, acute pain due to trauma, and chronic migraine headaches.</p> <p>R9's Physician's orders dated 8/28/24, included tramadol HCL oral tablet 50 milligrams give 50 milligrams by mouth two times per day as needed for pain related to chronic pain syndrome and oxycodone five milligram tablet give one half to one tablet every four hours as needed for pain.</p> <p>Review of R9's individual narcotic record and MAR dated from 8/1/24 through 9/30/2024, indicated four doses of oxycodone and one dose of tramadol documented on the individual narcotic record as removed but not documented on the MAR as administered.</p> <p>A facility document titled Pain Interview dated 9/25/24, indicated R9 reported headaches rated 10 out of 10 on a one through 10 pain scale and pain medication use four out of five days for headaches.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interview on 10/2/24 at 1:34 pm, R9 indicated no concerns with neck pain from fractures. R9 stated pain was from chronic migraines and not new. R9 further stated no concerns with getting tramadol or oxycodone pain medications when needed and reported a new medication order for celebrex oral capsule 100 milligram capsule every 12 hours as needed was working well and giving relief for headaches.</p> <p>R10's admission MDS dated [DATE], identified R10 had intact cognition and diagnoses of fracture of shaft of right tibia and fibula, fracture of right foot, mood disorder due to known physiological condition with depressive features, depression, anxiety disorder, and unspecified pain.</p> <p>R10's Physician's Order Sheet printed on 10/1/24, indicated a physician order for oxycodone five mg by mouth every four hours as needed for pain.</p> <p>R10's MAR indicated the controlled medication that was signed out of the narcotic log book by TMA-A was not documented as administered in R10's electronic health record.</p> <p>R10's record indicated no negative outcomes occurred from not receiving the narcotic medications.</p> <p>R11's discharge MDS dated [DATE], indicated intact cognition, diagnoses of sacral (lower back) fracture with routine healing, femur fracture with routine healing, chronic pain syndrome, and long term use of opiate analgesic (pain medication). MDS further indicated scheduled and as needed pain medication use, almost constant pain presence, pain frequently affecting sleep, therapy, and daily activities.</p> <p>R11's Physician's orders dated 8/28/24, included oxycodone HCL oral tablet 10 milligrams by mouth every six hours as needed for pain related to chronic pain syndrome.</p> <p>Review of R11's individual narcotic record and MAR dated 8/28/24 through 9/10/24 indicated four doses of oxycodone were signed out of the individual narcotic record but were not documented on the MAR as administered.</p> <p>R11 discharged from the facility on 9/10/24 and did not respond to phone call for interview.</p> <p>R12's significant change MDS dated [DATE], identified R12 had severe cognitive impairment and diagnoses of senile degeneration of the brain and anxiety.</p> <p>R12's Physician's Order Sheet printed on 10/2/24, indicated a physician order for lorazepam (antianxiety medication) 0.5 mg by mouth every four hours as needed for agitation related to senile degeneration of the brain.</p> <p>R12's MAR indicated the controlled medication that was signed out of the narcotic log book by TMA-A was not documented as administered in R12's electronic health record.</p> <p>R12's record indicated no negative outcomes occurred from not receiving the narcotic medications.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>When interviewed on 10/1/24, at 2:05 p.m. the director of nursing (DON) stated RN-B brought it to her attention. RN-B had been doing rounds with the provider. One of the residents insisted they were not taking that much Oxycodone. RN-B brought the narcotic book and noticed that the same staff member was signing the Oxycodone out of the narcotic book. The DON instructed RN-B to look for more incidents, after two more were brought to her a whole investigation was launched into all controlled medications. We completed pain assessments and found that no resident had uncontrolled pain due to not receiving their pain medication.</p> <p>During interview on 10/2/2024 at 1:43 p.m., R1 stated he was not receiving the amount of oxycodone that was documented. R1 stated he told the provider and RN-A that he took oxycodone approximately once a day if even and never three times a day. R1 stated he was told that oxycodone was signed out up to three times a day frequently and he knows that he did not receive those medications. R1 stated he thought it was strange when the TMA-B, that worked in the evenings, would come in and ask him how his pain was and when he asked why she was asking, TMA-B stated that she was following up on his pain following his pain medication to see if it was effective. R1 stated that he never received pain medication earlier with TMA-B stating it was signed off. R1 stated he bet that TMA-A signed it out and again stated that he never received those medications. R1 stated that occurred on several different occasions.</p> <p>During interview on 10/2/24 at 1:50 p.m., LPN-A stated when administering a PRN narcotic, she signed the narcotic out in the narcotic logbook and then would document the administration in the EMAR for that resident.</p> <p>During interview on 10/2/2024 at 2:17 p.m., R7 stated his pain was well-managed and would experience more pain when not positioned correctly in his wheelchair. R7 stated his pain medications are scheduled and that he had only needed to ask for an as needed dose one time since admission.</p> <p>During interview on 10/2/2024 at 3:19 p.m., RN-A stated she was rounding with the provider who asked RN-A how often R2 was taking his oxycodone. RN-A reviewed the narcotic logbook with the provider. RN-A stated the provider was asking R2 about constipation issues related to oxycodone use. R2 stated he had only taken one dose of oxycodone since his admission. RN-A informed R2 of the doses of oxycodone that were signed out with R2 responding if he was taking oxycodone, he was not aware of it. RN-A stated she updated the director of nursing (DON) thinking TMA-A may need re-education on administration of PRN medications. RN-A stated she then rounded with R1's provider who came in specifically for a medication visit and oxycodone renewal. Provider asked RN-A how many times R1 was taking oxycodone with RN-A reviewing the narcotic logbook which indicated R1 was taking the PRN oxycodone one to three times a day. R1 stated to provider and RN-A he took as needed oxycodone maybe once a day, sometimes two times but never three times. R1 asked if TMA-A was documenting the narcotic administration. R1 thought it was suspicious when TMA-B, who worked in the evenings, would come in and ask if the oxycodone was effective. R1 stated he told TMA-B that he never took an oxycodone. RN-A stated she notified DON who began investigation and found that there were 24 doses signed out of the narcotic logbook but was not documented on the EMAR.</p> <p>During interview on 10/2/24 at 4:26 p.m., TMA-A stated she documented the oxycodone in the narcotic logbook but would forget to document them in the EMAR. TMA-A stated the reason for forgetting to document them in the EMAR was that she got lazy with her job and become a disgruntled employee.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interview on 10/3/24 at 9:03 a.m., TMA-B stated that she would ask the resident what they wanted the narcotic for and get a specific reason and would always let her charge nurse know so they were aware of what occurred during her shift. TMA-B stated if a narcotic was administered during the day shift, she would follow up with the resident to see if the narcotic was effective or not. TMA-B stated she asked R1, several times towards the beginning of her shifts, if his oxycodone was effective with R1 stating that he did not receive the oxycodone. TMA-B stated she would tell him according to the record, TMA-A gave the oxycodone to R1. R1 was adamant he did not receive that dose of medication. TMA-B stated this started in September. TMA-B did not think anything of it due to TMA-A being pregnant and assumed not able to consume the narcotic. TMA-B stated looking back on it now, she realized she should have reported it sooner. TMA-B stated if she was suspicious of medication diversion, she would immediately go to the charge nurse and report it.</p> <p>When interviewed on 10/3/24, at 1:19 p.m. the DON stated, they had done re-education on the updated controlled substance policy, all staff that touch medications had been re-educated with exception of one nurse on vacation who will be re-educated upon return. Education included notifying the nurse or DON if a resident state they did not receive a medication despite documentation showing they did. They did not drug test the staff person, the evidence was so overwhelming the result would not have mattered, she started with a couple of pills here and there, in about August had significantly increased with the number of doses.</p> <p>In a subsequent interview on 10/3/24, 4:44 p.m. the DON stated the expectation was staff follow the policy, if residents requested an as needed (PRN) medication or it's identified they were having pain, the TMA would talk to the nurse who was responsible to assess the resident then direct the TMA on what medication to give. The nurse was expected to follow up with the resident to assess effectiveness of pain medication.</p> <p>The facility's Controlled Substances policy dated 9/24, directed controlled substances will be prepared following the guidelines within Medication Guidelines. Controlled substances will not be removed from their secure storage until ready to prepare for administration. Controlled substances will be documented at the time of removal from secure storage and will be administered immediately by the individual removing them from their secure storage. Controlled substance record will be thoroughly documented to include:</p> <ol style="list-style-type: none"> a. Date and time of administration b. Dose being administered. c. Route of administration d. Signature of the authorized personnel e. Amount remaining <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Discrepancies of Controlled Substances - any controlled substances which are unaccounted for will be immediately reported to the director of nursing services and/or their designee. All authorized personnel that are present at the time of the discrepancy may be asked to remain in the facility until the discrepancy is resolved. The Director of Nursing Services and/or their designee will review the discrepancy and attempt to identify the cause of the discrepancy which may include but is not limited to: recalculating the documented dose administered and amount remaining for that controlled substance, review and comparison of doses administered documented within the medication administration record for that resident and/or other residents with same/similar medications, review of controlled substance delivery records, communication with the providing pharmacy, etc. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the Administrator a report of such findings.</p> <p>The facility's Medication Administration by Unlicensed Personnel policy dated 9/23, indicated the unlicensed personnel may administer PRN medications if approved by the licensed nurse.</p> <p>This Immediate Jeopardy (IJ) is being issued at Past noncompliance (PNC) after it was verified the facility put the following corrective action in place.</p> <p>-Staff education was initiated on 9/27/24 which included the following topics: Medication Administration by Unlicensed Personnel and Controlled Substances training including:</p> <p>Ensuring the meds are secure at all times,</p> <p>Every dose given must be documented in the narcotic record and the electronic medication administration record,</p> <p>At the time of follow up for a PRN medication, if a resident denies receiving the medication, immediately report it to the nursing supervisor for review.</p> <p>-AP was immediately suspended and then was terminated concluding investigation.</p> <p>-Management conducted audits on all residents with prescribed controlled medications to confirm medications were not diverted.</p> <p>48013</p> <p>50764</p>		

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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>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40938</p> <p>Based on interview and document review, the facility failed to ensure narcotic and controlled substances destruction was completed in accordance with established policies and procedures to reduce the risk of diversion and/or theft.</p> <p>Findings include:</p> <p>10/2/24, 9:00 a. m. Review of narcotic books, Certificate of the Inventory and Destruction of Controlled Substances Form :Long Term Care Facilities, and Medication Disposition Log - Resident Record Identified 7 medication cards which contained 123 tablets of Oxycodone (narcotic pain medication), 11 cards which contained 175 tablets of lorazepam (controlled substance for anxiety), one card with 30 tablets of temazepam (controlled substance for insomnia), two cards with 36 tablets of pregabalin (controlled substance for nerve pain), two cards with 44 tablets of tramadol (opioid medication for pain) and one bottle of morphine with 14.5 milliliters (ml) remaining, were signed out of the narcotic books as destroyed, however, they were not documented on Destruction of Controlled Substances Form or the Medication Disposition Log - Resident Record.</p> <p>10/2/24, at 1:45 p.m. Review of prairie medication cart controlled locked drawer with licensed practical nurse (LPN)-B identified one card of hydromorphone remained in the drawer despite being discontinued for use on 6/5/24, one card of Oxycodone discontinued 9/23/24, two cards of methylphenidate discontinued 9/20/24, one card of lorazepam discontinued 9/18/24, two cards of Oxycodone discontinued 9/25/24, and one card of diazepam discontinued 9/23/24.</p> <p>10/2/24, at 2:01p.m. interview with LPN-B when medications are discontinued, they should be removed right away, if they are not, it is a med error or diversion waiting to happen. Two nurses sign the medication out of the narcotic book and fill out two other forms, before putting into the Medsafe,</p> <p>10/2/24, 4:00 p.m. Interview with registered nurse (RN)-B on 8/26/24 found the box from the med safe sitting in the director of nursing (DON) office, not sure how long the liner was in the office. RN-B called for pick up on 8/27/28 and then placed it at the front desk for pick up on 8/28/24. RN-B received a call on 9/4/24, from front desk, the box was still there. RN-B called for pick up again, it was picked up a couple hours later.</p> <p>10/3/24, 9:10 a.m. interview with scheduler. The med box was last picked up about two weeks ago. The box sat behind the desk. Scheduler believed it was locked in the office at night and brought back out in the morning.</p> <p>10/3/24, 10:09 a.m. interview with business office, the box with meds didn't get picked up, it was locked it in the office at night then put it back behind the desk in the morning. Business office believed it was locked in the office two different times.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245416	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Cura of Le Sueur		STREET ADDRESS, CITY, STATE, ZIP CODE 621 South 4th Street Le Sueur, MN 56058	
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>10/3/24, 11:43 a.m. interview with pharmacy consultant, expectation for anything placed into the med safe should be on the Certificate of the Inventory and Destruction of Controlled Substances Form. When the med safe liner was full the facility expected to call pharmacy for the second key. Driver must be present when two liner was changed in medsaf. Both staff sign liner change log. Expected liner was locked in secure office for maximum of three days before picked up by UPS. Destruction form was not completed, pharmacy consultant concerned medications were not placed in medsaf. No logs were kept indicating facility contacted pharmacy for liner change or medications placed into medsaf.</p> <p>10/3/24, 4:42p.m. interview with DON, was informed the med safe liner was in the office for an undetermined amount of time. DON was not aware the liner was out of this office for eight days. The policy indicated liner to be locked and secured in this office, if DON was not in office the door needs to be locked. Sign to be placed at reception desk directing pick up person to see DON. Need to make this interview more of a reference to what should happen . less like what the DON actually said, unless putting in quotes.</p> <p>A facility provided Discarding and Destroying medications policy dated 11/2021, identified facilities could contract with a Drug Enforcement Agency (DEA) registered collector, controlled substances may be disposed of in authorized collection receptacle located at the facility. Disposal of controlled substances must take place immediately (no longer than three days). Documentation of disposal on the medication disposition record.</p> <p>A facility provided Medsafe Medication Disposal policy dated 2/2024, identified, schedule pharmacy for medsaf liner exchange should occur two or more days in advance so UPS can be scheduled to pick up inner liner the same day of removal. Both DON and pharmacy employee will remove inner liner, seal liner, document on Inner Liner Log, both will insert new liner into medsaf and document in inner liner log. DON to place sign at front desk informing the UPS driver to see DON for package.</p>		