STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245447	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sacred Heart Care Center	1200 12th Street Southwest Austin, MN 55912

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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 51576 Based on interview and document review the facility failed to implement their abuse prohibition policy when there was an allegation of misappropriation of resident property for 1 of 1 resident (R1) reviewed for drug diversion. Findings include: R1's face sheet dated 4/29/25, identified diagnoses of dementia (memory loss), bipolar disorder (disorder associated with episodes of mood swings), and chronic kidney disease (damage to the kidneys). R1's hospice orders dated 3/18/25, identified morphine sulfate (a medication used for pain) and lorazepam (medication used for anxiety). Licensed practical nurse (LPN)-E sent an email on 4/11/25 at 10:57 p.m.,to registered nurses (RN)-B, RN-C, RN-D, and interim director of nursing (IDON) identifying R1's liquid morphine bottle was way off. There were 16.5 milliliters (ml) in the bottle and at the end of her shift there was 12 ml left in the morphine bottle. LPN-E requested the nurse managers to look into the situation and identifed the narcotic page number. Follow up email dated 4/11/25 at 10:59 p.m., identified RN-B replied to LPN-E asking if that's what it was at when you did narcotic checks coming on shift. There was no evidence of an email follow up on RN-B's question to LPN-E. LPN-E sent another email to RN-B on 4/12/25 to report that R1's lorazepam count was off as well and was at 10 ml and was supposed to be at 12 ml. LPN-E responded to RN-B question about the liquid morphine stating, I can't remember what the bottle was at the start of the shift, but I did not spill, when I left last Friday, everything was on track. During an interview on 4/29/25 at 12:31 p.m., registered nurse (RN)-B stated she received an email on 4/11/25 at around 11:00 p.m. to inform her of R1's narcotic count not being correct. RN-B stated she did not complete a facility narcotic count to ensure if other narcotics were missing. She called the facility the next day and the nurse that was working believed the loss of narcotic was due to spillage or evaporation and RN-B did not think anything of it. after talking to the nurse. RN-B did not report R1's narcotic count being incorrect until 4/14/25 or start an investigation as a result of the missing medication. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/25 at 2:31 p.m., the Administrator stated she had not received a report about R1's narcotic count being off until the afternoon on 4/14/25. However, she did not initiate an investigation at that time attributing the discrepancies to spillage or evaporation. The Administrator further noted that an investigation into R1's missing narcotics was only initiated after she received an anonymous note under her door on April 17, 2025, alleging narcotic diversion involving R1. The note specifically suggested investigating the destruction of R1's narcotics on April 15, 2025, as the counts had been inaccurate at the time of destruction. After she received the anonymous note on 4/17/25 she had the nurse managers perform a count of all the liquid narcotics in the facility on 4/17/25. Administrator stated, they were unable to pinpoint missing narcotics to just one nurse, since it had been multiple nurses recording R1's amounts incorrectly. The facility was unable to provide an investigation into the incident but provided documentation of training for the nurses on performing narcotic counts. However, this training did not include guidance on reconciling narcotics. Review of the facility's Abuse, Neglect, Mistreatment and Misappropriation of resident property policy dated 3/14/24, identified the following: Investigation regarding misappropriation -Complete an active search for missing item(s) including documentation of investigation. -The investigation will consist of at least the following: A review of the completed complaint report An interview with the person or persons reporting the incident. Interviews with any witnesses to the incident A review of the resident medical record if indicated. A search of resident room (with resident permission) An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident. Interviews with the resident's roommate, family members, and visitors A root-cause analysis of all circumstances surrounding the incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51576 Based on interviews and document review the facility failed to report to state agency (SA) potential misappropriation of resident property (missing narcotics) no later than twenty-four after an allegation was made for 1 of 3 resident (R1) reviewed for narcotic diversion. Findings included: R1's face sheet dated 4/29/25, identified diagnoses of dementia (memory loss), bipolar disorder (disorder associated with episodes of mood swings), chronic kidney, and chronic kidney disease (damage to the kidneys). R1's hospice orders dated 3/18/25, identified morphine sulfate (a medication used for pain) and lorazepam (medication used for anxiety). During an interview on 4/29/25 at 12:31 p.m., registered nurse (RN)-B stated she received an email on 4/11/25 at around 11:00 p.m., from one of the nurses stating that one of R1's narcotic count was not correct in the narcotic record. RN-B stated she responded via email on 4/11/25, however, did not call the facility until the next day to begin determination of the missing narcotics. RN-B stated she did not report R1's missing medication to the Administrator until the afternoon on 4/14/15, because she did not think it was a concern. During a follow up interview at 4:54 p.m., registered nurse (RN)-B stated she was unsure of the timeframe for reporting a possible drug diversion to the SA but believes it would be within 24 hours and she should have notified the administrator on 4/11/25. During an interview on 4/29/25 at 2:31 p.m., the Administrator stated she had not received a report about R1's narcotic count being off on 4/11/25 until the afternoon on 4/14/25, however did not report this to the state agency at that time, because the investigation determined it was not a drug diversion, however the investigation was not completed until 4/18/25. During an interview on 4/29/25 at 11:56 a.m., RN-A stated if a medication is missing, she would notify the administration immediately and it would need to be reported within 24 hours to the SA. Review of the facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy dated 3/13/24, identified that all alleged violations of misappropriation of resident property are reported no later than 24 hours, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51576 Based on observation, interview, and document review the facility failed to implement policies and procedures to ensure accurate reconciliation of controlled substances to ensure rapid detection of potential narcotic diversion for 2 of 3 residents (R1, R3) reviewed for medication pass who received narcotic medications. Findings include: R1's face sheet dated 4/29/25, identified diagnoses of dementia (memory loss), bipolar disorder (disorder associated with episodes of mood swings), and chronic kidney disease (damage to the kidneys). R1's hospice orders dated 3/18/25, identified morphine sulfate (a medication used for pain) and Lorazepam (medication used for anxiety). Review of R1's Individual Narcotic Record for morphine sulfate concentrate (RX#233843) identified the following: -Page 69 of the narcotic record identified on 3/18/25 (RX# 2333843) 30 milliliters (ml) was received from pharmacy. On 4/1/25 remaining amount was 22.50 ml and was transferred to page 79. -Page 79 of the narcotic record identified on 4/1/25 (RX# 2333843) 22.50 ml moved from page 69. On 4/13/25 remaining amount of 14.75 ml was transferred to page 97. -Page 97 of the narcotic record identified on 4/13/25 (RX# 2333843) 14.75 ml transferred from page 79. On 4/15/25 at 1:35 p.m., the narcotic record identified that remaining amount was 13 ml. On 4/15/25, the narcotic record identified that 13 ml was wasted, with two nurses signatures on page. However, there was a correction note on 4/15/25 that identified 9 ml were destroyed with three initials, one was the director of nursing (DON). However, there was no indication for the change. Review of R1's Individual Narcotic Record for Lorazepam identified the following: -Page 86 of narcotic record identified on 4/14/15 remaining amount was 10.5 ml. On 4/15/25 the amount destroyed was 8.5 ml, signed by two nurses. However there was no indication why 8 ml were wasted instead of 10.5 ml as identified in the narcotic record. During an interview on 4/29/25 at 10:40 a.m., licensed practical nurse (LPN)-B stated narcotics are counted at the beginning and end of each shift by two nurses. LPN-B stated R1's morphine and Lorazepam counts had been off for a while; however, could not identify how long. She and other nurses continued to document what the count was supposed to be with the doses given and not what was present in the bottle. LPN-B further stated she had been told by the nurse managers the counts could be off due to spillage or evaporation. LPN-B stated LPN-E had send an email to the nurse managers on 4/11/25 to notify that R1's counts were not correct, but was unsure what occurred. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-B reviewed R1's narcotic record on April 15, 2025, and noted the recorded amount was 13 ml of morphine. However, when she physically checked the bottle at 1:35 p.m. that same day, she found only 9 ml left. To align with the narcotic log, she documented an incorrect remaining amount. LPN-B did not notify the nurse managers about the discrepancy since another nurse had already done so. During an interview on 4/29/25 at 12:31 p.m., registered nurse (RN)-B stated that nurses had not been recording the correct amount in R1's narcotic record during shift-to-shift narcotic count because they may be off due to spillage or evaporation. The liquid Lorazepam was kept in a locked refrigerator in the front of the wings and was unsure if the nurses were performing the counts on these bottles at shift change. R3's face sheet dated 4/29/25, identified diagnoses of dementia, chronic kidney disease, diabetes (disease where the body use sugar as fuel). Review of R3's individual narcotic record for morphine sulfate concentrate identified the following: -Page 19 of the narcotic record identified on 4/6/25 that 26.50 ml of morphine sulfate 20 mg/ml was transferred from old book. On 4/29/25 R1's morphine count was recorded at 26.50 ml at shift change. During an observation and interview on 4/29/25 at 11:49 a.m., LPN-C removed R3's morphine sulfate (20 mg/ml) bottle out of locked medication cart and held R3's morphine bottle in the air stating R3's morphine bottle had around 25 ml in the bottle. LPN-C then placed R3's bottle on the top of the medication cart and leaned over to read the side of the bottle on the cart and stated R3's morphine bottle was closer to 24 ml mark. Observation of R3's morphine sulfate 20 mg/ml bottle had a blue liquid substance in it with lines on one side with measurements and the blue liquid substance was at the 24 ml mark. LPN-C stated R3's bottle had been off for quite some time and the previous director of nursing had talked to the consulting pharmacist and stated the liquid bottles can appear to have less in the due to spillage or evaporation. LPN-C stated R3's narcotic record had not been corrected to the correct amount and nurses have been recording in the log what the amount is supposed to be not what was in the bottle. LPN-C further stated when she performs narcotic counts at the beginning or end of her shift and the count would not be correct then she would contact the nurse managers immediately, however had not informed the nurse managers about the R3's count being off. During an interview on April 29, 2025, at 1:02 p.m., the interim director of nursing (IDON) stated that she assisted in the destruction of R1 ' s morphine and Ativan alongside a second nurse on April 15, 2025. Initially, both nurses documented the expected amount in the narcotic log, but later corrected the wasted amount upon discovering discrepancies in the medication count. IDON reported that she contacted the consulting pharmacist about the discrepancy. She had been told about possible spillage or evaporation but could not recall the exact date of the discussion. IDON stated her expectation would be for nurses to do narcotic counts at the beginning or end of their shifts and if the counts are not correct they should notify the director of nursing or administrator immediately and not sign the narcotic record until the medication can be accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 4/30/25 at 8:17 a.m., consulting pharmacist (Pharm) stated she was not aware of R1's narcotic counts being incorrect until the medications were destroyed on 4/15/25. She had received a call from the IDON to discuss R1's counts being off and suggestions of how this could have occurred. Pharm further stated when a resident's narcotic count are not correct during count, then administration and pharmacist should be notified immediately to account for the medication loss and ensure a diversion had not occurred. Pharm further stated she does not perform routine reconciliation of the narcotics and the facilities will do this. She stated liquid narcotics can show slight discrepancies in volume due to various factors, including the type of syringe used, errors in dosage measurement, and loss from spillage or evaporation as staff frequently access the medication bottles. When the facility noticed the liquid narcotics being incorrect then they should have provided education to the nurses on proper reconciliation of narcotics and what to do when the counts are incorrect. Review of the facility's Medications-Controlled Policy and Procedure dated 1/13/25 and unsigned by DON or Medical Director, identified the following: - narcotics are to be counted at the change of each shift by the off-going and the on-coming nurse and both sign the change of shift count record. -if the count is incorrect, and you cannot resolve the count, notify the supervisor. -Both nurses must stay until the supervisor tells them that they may leave. -Do not adjust the count of leave spaces in the book. -Only those nurses who do the actual count should sign that the count is correct.