DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: February 14, 2022

Dear Administrator:

On February 28, 2022, we notified you a remedy was imposed. On March 16, 2022 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 15, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 15, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 28, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
February 28, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: February 14, 2022

Dear Administrator:

On February 14, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 14, 2022, the situation of immediate jeopardy to potential health and safety cited at F602 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 15, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 15, 2022, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions

effective March 15, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 14, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.
Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Franciscan Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective

February 14, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may

call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for

the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH CENTER	**3910 MINNESOTA AVENUE DULUTH, MN 55802**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/10/22, through 2/14/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F602 began on 1/25/22, when registered nurse (RN)-B notified the administrator and the director of nursing (DON) via email with her concerns LPN-B was giving narcotics to residents when she was able to control their pain with Tylenol, thus diverting narcotics. The administrator and director of nursing (DON) were notified of the IJ on 2/11/22, at 4:30 p.m. The IJ was removed on 2/14/22, at 3:30 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/14/22. The following complaints were found to be SUBSTANTIATED: H5258061C (MN80836), with deficiencies cited at F602. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 03/03/2022

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.

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 602 SS=J	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R1, R2, R3) reviewed for drug diversion were free from exploitation when a staff member took resident's narcotic pain medications for personal use. This resulted in an immediate jeopardy (IJ) when licensed practical nurse (LPN)-B diverted 134 oxycodone tablets, and 18 Percocet tablets. The immediate jeopardy (IJ) began on 1/25/22, when registered nurse (RN)-B notified the administrator and the director of nursing (DON) via email with her concerns LPN-B was giving narcotics to residents when she was able to control their pain with Tylenol, thus diverting narcotics. The administrator and the DON failed to conduct a thorough investigation, failed to remove LPN-B from working while they conducted an investigation, and failed to notify law enforcement. The administrator and DON were notified of the IJ on 2/11/22, at 4:30 p.m. The IJ was removed on 2/14/22, at 3:30 p.m. but	F 602	F 602 Free from Misappropriation/Exploitation The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • On 2/10/2022 at 3:09pm the reported potential misappropriation/Exploitation was investigated and a report filed to the State Agency (SA), Tracking ID 346117. Police report filed, Board of Nursing notified and Medical Director and Consultant Pharmacist notified. • On 2/10/2022 LPN-B was interviewed and suspended upon completion of investigation. LPN-B has been terminated effective 2/17/2022. • On 2/10/2022 R1 pain assessment and medical record review completed by Nurse Manager BM and found to be at baseline. R1 was not noted to be in pain or impacted. Physician and family notified.	3/15/22

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F 602	Continued From page 2 non-compliance remained at the lower scope and severity of D, potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Face Sheet printed on 2/11/22, indicated R1's diagnoses included restless leg syndrome, osteoarthritis of the knees, migraines, dementia and depression. R1's Physician's Order Sheet indicated on 2/18/21, the physician ordered oxycodone (an opioid medication used to treat moderate to severe pain) 2.5 milligrams (mg) by mouth two times a day at 8:00 a.m. and 8:00 p.m. for pain. R1's Active and Inactive Orders sheet indicated on 2/5/22, R1's oxycodone 2.5 mg by mouth every eight hours as needed for pain, was discontinued due to R1 not utilizing. R2's Face Sheet printed on 2/11/22, indicated R2's diagnoses included pain in the left and right knees and legs, restless leg syndrome, Parkinson's disease and anxiety. R2's Physician's Order Sheet indicated on 9/30/21, the physician ordered oxycodone extended relief, 20 mg by mouth every 12 hours at 8:00 a.m. and 8:00 p.m. for pain in the left and right knees and legs. The documents provided did not include an order for oxycodone one tablet by mouth every six hours as needed. R3's Face Sheet printed on 2/11/22, indicated R3's diagnoses included shoulder pain, spasmodic torticollis (a condition in which the neck muscles contract causing the head to twist to one side), recurrent dislocation of the left	F 602	• R2 not directly impacted as narcotics were additional medications not needed by resident. Physician and family notified. • R3 not directly impacted as resident had passed prior to alleged misappropriation/exploitation. Physician notified. • All residents who have orders for controlled substances have potential to be impacted by this practice. • On 2/11/2022 all residents who have orders for controlled substances had their narcotic records reviewed for any discontinuation and destruction that would have been completed by LPN-B to determine compliance with second licensed staff verification, Completed by Nurse Manager BM. No irregularities or variances identified. • On 2/11/2022 all residents who are interview able and have narcotic orders were interviewed by Activity Director LF to identify if they have had any history of unrelieved pain, No concerns were identified by the residents. • IDT policy review took place regarding policies titled Controlled substances and Drug diversion. Procedure for Destruction of Narcotics reviewed and updated as follow: Director of Nursing will be involved with all Narcotic destruction. • On 2/11/2022 at 6:30pm Education provided to Administrator of record BL and DON BS regarding conducting thorough investigations when potential drug diversion is reported, completed by Quality consultant SB. • Starting on 2/11/2022 Administrator BL and DON BS performed education to	

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F 602	Continued From page 3 shoulder and depression. In addition, the Face Sheet indicated R3 had expired 12/29/21. R3's Active and Inactive Orders sheet indicated R3 had an order on 2/6/20, for oxycodone-acetaminophen (Percocet, an opioid pain medication consisting of a combination of oxycodone and acetaminophen [Tylenol] used to moderate to severe pain) 5/325 mg by mouth every four hours as needed for pain. The order included a finish date of 12/29/21. Review of R1, R2, and R3's medical records indicated none of the residents had negative outcomes from not recieving their narcotic medications. Review of the facility's narcotic books on the Lakeside unit and Bayside unit medication carts indicated the following: The Lakeside unit narcotic Book One, page 13, indicated on 1/27/22, 30 oxycodone tablets (Rx number 1591088) were received for R1. On 2/5/22, at 7:00 p.m. The book indicated 14 tablets remained. The page was crossed off with an X with a date of discontinuance of 2/5/22. There was no signature on the page. The Lakeside unit narcotic Book Two pages 105, 106, 107, and 108, indicated on 11/30/21, 120 oxycodone tablets (Rx number 1589497) in four cards of 30 tablets each were received for R2. Each page indicated 30 tablets remained. Each page was crossed off with an X with a notation at the bottom of each page of D/C'd (discontinued) without a signature or date. The Bayside unit narcotic book page 22 indicated	F 602	all Licensed Nurses and Trained Medication Aides regarding Controlled substance policy, Drug Diversion policy and Narcotic destruction procedure. • All new hires who are licensed nurses or Trained medication aides will be trained on procedures on narcotics, narcotic storage, reordering and counting of narcotics. • On 3/9/2022 and 3/10/2022 Thrifty White pharmacy Nurse Consultant scheduled to perform medication administration audits. • Auditing of narcotic counting, residents received narcotics as ordered and narcotic destruction to ensure completed per facility policy, auditing will take place 3x/week until compliance is achieved and quarterly there after by the Director of nursing or designee. Director of Nursing will report the findings to the IDT team. • Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	

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F 602	Continued From page 4	F 602		

on 12/20/21, 30 Percocet 5/325 tablets (Rx number 1587582) were received for R3. On 12/29/21, at 6:35 p.m. The book indicated 18 tablets remained. The page was crossed off with an X, and lacked a date, signature or notation of why the page had an X over it.

Review of the facility's Destruction of Controlled Substances book indicated the following:

R3's oxycodone/acetaminophen 5/325 (Rx number 1587582) 18 tablets was destroyed on 12/29/21, with two signatures. One signature was that of LPN-B and the other signature was illegible.

On a separate page of the book, with no other controlled medications listed, were R2's oxycodone 5 mg (Rx number 1589497), 120 tablets destroyed on 12/29/21, with two signatures and R1's oxycodone 2.5 mg (Rx number 1591088) 14 tablets destroyed on 2/5/22, with two signatures. One signature was that of LPN-B and the other signature was illegible.

On 2/8/22, LPN-A submitted a report to the State Agency (SA) which indicated on the evening of 2/7/22, at 10:30 p.m. LPN-A was doing the shift narcotic count with the off-going unnamed registered nurse (RN), and there were no notable discrepancies. After count was done and the RN had left, LPN-A noticed a page in the narcotic book was crossed out (Lakeside unit narcotic book two, page 13). The page indicated R1 had 14 oxycodone 5 mg half tablets remaining on the page, but the medication card (number 13) was not in the locked narcotic drawer. There was no proof the oxycodone was destroyed in the narcotic book, and there was no proof of the

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FRANCISCAN HEALTH CENTER	**3910 MINNESOTA AVENUE DULUTH, MN 55802**

(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) COMPLETION DATE
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destruction being done in the narcotic destruction book. The narcotic book only indicated R1's oxycodone was discontinued per MD order. The same page also included R1's scheduled dose of oxycodone 5 mg half tablets was still an active order. The medication card containing R1's oxycodone should have remained in the narcotic drawer and should have been used for her scheduled oxycodone. Also in the narcotic book, pages 105, 106, 107, 108 were R2's oxycodone 5 mg tablets, and all pages were crossed out, indicating it was discontinued. However, these medications were signed destroyed by LPN-B, and co-signed with an illegible signature.

R1 had a total of 14 missing oxycodone tablets and R2 had a total of 120 missing oxycodone tablets. R3 had a total of 18 missing Percocet tablets.

On 2/10/22, at 12:04 p.m. LPN-C was interviewed and stated R3's Percocet 5/325 mg of which the narcotic book indicated there were 18 tablets, was not in the medication cart. LPN-D stated she then checked the narcotic destruction book. The narcotic destruction book indicated on 12/29/21, R3's Percocet was destroyed by LPN-B and LPN-A. LPN-C further stated the signature did not look like LPN-A's signature, it did not match. LPN-C left the interview to alert the director of nursing (DON).

On 2/10/22, at 12:15 p.m. LPN-D was interviewed and stated he had reordered R1's oxycodone on 2/6/22, and indicated on the reorder sheet the oxycodone was "out" with a question mark next to the RX number. LPN-D stated he was looking for R1's oxycodone, and it was not in the medication cart. LPN-D stated he did not know where R1's

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	245258	A. BUILDING _____ B. WING _____	C 02/14/2022

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oxycodone may have gone.

On 2/10/22, at 2:13 p.m. the DON reviewed the signatures on R3's narcotic log. The DON stated the signatures were of LPN-B and registered nurse (RN)-A. The DON stated he compared RN-A's signature to the signature on file, and stated it was questionable that the narcotic log had the same signature. The DON further stated no one had informed him of any missing narcotics last week or this week. The DON stated at the end of January, he did an audit of narcotics because RN-B was questioning why LPN-B (who worked opposite days of RN-B) was giving the residents narcotics, when she was giving them Tylenol which relieved their pain. The DON stated at that time, he did not believe there was any drug diversion. The DON was unsure what happened to R3's Percocet, and stated he would investigate.

On 2/10/22, at 2:16 p.m. the DON and administrator were interviewed. The DON stated the nurse practitioner came late Friday, 2/4/22, and discontinued R1's as needed (PRN) oxycodone. The orders were processed on Saturday 2/5/22. The DON stated LPN-D worked a 12 hour day to evening shift, and LPN-B worked a 12 hour evening to night shift on Saturday 2/5/22. LPN-D gave R1 her scheduled 8:00 a.m. and 8:00 p.m. oxycodone on Saturday 2/5/22. When LPN-D returned to work on Sunday 2/6/22, R1's oxycodone was not in the medication cart. LPN-D then attempted to order the oxycodone from the pharmacy. LPN-D did not report the missing oxycodone because he got busy, and the medication came in on Sunday. The DON stated it seemed "weird" that LPN-B would take R1's oxycodone knowing the next nurse to follow him

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was LPN-D. The DON verified R2 was missing 120 oxycodone tablets.

On 2/10/22, at 2:46 p.m. RN-B was interviewed and stated she emailed the administrator and the DON on 1/25/22, primarily questioning why narcotics were being signed out by LPN-B for residents who do not ask for narcotics at night. RN-B stated she talked to the DON on the previous Friday and was told he was looking into it. RN-B further stated it seemed suspicious because narcotics were being signed out for residents who slept through the night when she worked. RN-B stated she worked the opposite night shift of LPN-B. RN-B provided a copy of the email she had sent to the administrator and the DON.

On 2/10/22, at 3:00 p.m. LPN-A was interviewed. LPN-A stated she and trained medication aide (TMA)-A found major discrepancies between the narcotic books for both the Bayside unit nursing cart and Lakeside unit nursing cart. LPN-A stated R2 had over 120 missing narcotic medications in the Lakeside unit narcotic book. The narcotic destruction book indicated LPN-B destroyed the narcotics. LPN-A stated this appeared suspicious to her because the signatures in the narcotic destruction book were of LPN-B, and the other signature was not readable. LPN-A did not report it to the DON or administrator, and stated it was because in the past, she had felt her concerns had been "brushed off."

On 2/10/22, at 3:18 p.m. the DON stated he found an entry for R2's oxycodone in the narcotic destruction book on a separate page in the back of the book. The DON was able to identify LPN-B's signature but was unable to identify the

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second signature.

On 2/11/22, at 9:00 a.m. the administrator and the DON were interviewed again. The DON stated they had interviewed LPN-B, and he was evasive and defensive. LPN-B had told them he was unable to remember who co-signed with him when destroying the narcotics. LPN-B was unable to explain what happened with R1's medications and became defensive towards them.

On 2/11/22, at 11:19 a.m. the consultant pharmacist (CP)-A was interviewed. CP-A stated he was unaware of the narcotic diversion until last night when the facility called and informed him. CP-A stated when destroying narcotics, there needs to be two licensed staff, and one of those should be the DON, or ADON.

On 2/11/22, at 1:52 p.m. LPN-B was interviewed. LPN-B stated he was innocent and would not say anything further.

The facility's Drug Diversion policy dated 4/4/16, directed the facility would identify, thoroughly investigate and report suspected or known incidents of drug diversion.

The facility's Controlled Substances policy dated 7/18/16, directed controlled substances cannot be returned to the pharmacy for credit. If a controlled substance is discontinued, the dose changed or resident is no longer in the facility, the discontinued substance is to be removed as soon as workable from the substance cart using the following procedure: 1. On the count sheet, make an entry indicating the substance was transferred to the nursing director or designee for destruction. 2. Mark the count as 0 (zero). This act requires

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F 602	Continued From page 9 two signatures, the nurse that is initiating and the nursing director or designee that is taking the controlled substance for destruction. The IJ was removed on 2/14/22, when it was verified through staff interview and document review the facility implemented corrective action to prevent recurrence. LPN-B was suspended pending the facility investigation, the policies and procedures on controlled substances and drug diversion were reviewed by the IDT team, all narcotics were reviewed and counted, residents were interviewed and staff was educated. \	F 602		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: Event ID: JU0G11

Dear Administrator:

The above facility survey was completed on February 14, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/10/22, through 2/14/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5258061C (MN80836), however, NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		