DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5258062M
Compliance #: H5258061C

Date Concluded: April 18, 2022

Name, Address, and County of Licensee Investigated:
Franciscan Health Services
3910 Minnesota Avenue
Duluth, MN 55802
St. Louis County

Facility Type: Nursing Home

Evaluator's Name: Jill Hagen, RN,
Special Investigator

Finding: Inconclusive

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

Allegation(s):
It is alleged: The alleged perpetrator (AP), facility licensed staff, financially exploited Resident #1, Resident #2, and Resident #3, when the AP took the residents narcotic medications for his own use.

Investigative Findings and Conclusion:
It was inconclusive whether exploitation by drug diversion occurred. Although the AP failed to follow the facility's policies and procedures for discontinuing narcotic medications, the AP denied being trained and the AP's personnel file lacked facility training on the medication administration process. The AP denied taking the narcotic medications.

The investigation included interviews with facility staff members, including administrative staff and nursing staff. The investigation included a review of the residents' medical record, policies and procedures, the facility narcotic logs and narcotic destruction documentation, staff schedules, and the AP's personnel file. In addition, the investigator contacted law enforcement.

Resident #1 had diagnoses that included osteoporosis (brittle and fragile bones) with pain and dementia. Resident #1's pain medication included Oxycodone, an opioid analgesic, 2.5 milligrams (mg) two times a day and every four hours as needed (prn) for pain.

Resident #2 had diagnoses that included Parkinson's disease, dementia, and pain. Resident #2's pain medication included Oxycontin (an opioid analgesic) 20 mg every 12 hours, and a discontinued order for Oxycodone 2.5 mg every six hours prn for pain.

Resident #3 had diagnoses that included left shoulder pain and quadriplegia (paralysis of all four limbs). Resident #3's pain medication included Percocet (an opioid analgesic) 5-325 mg every four hours prn for pain.

The facility's policy and procedure for narcotic medications indicated when a narcotic is received by a pharmacy, staff entered each narcotic for individual residents in a narcotic logbook. The logbook contained the name of the resident and medication, the dose and frequency of the medication, and space for two licensed staff signatures to sign off when the narcotics were dispensed to residents and/or reconciled (counted) at the end and beginning of each shift. When a narcotic medication was discontinued, the facility process included placing a X across the page in the logbook, writing discontinued on the page, and required two licensed signatures and date to verity the discontinuation of the medication. Next, a licensed staff entered the narcotic medication on a medication destruction sheet with a second licensed staff signature who witnessed the destruction of the medication in a liquid.

The facility's incident report indicated there was a discrepancy between the narcotic logbook and the facility narcotic medication destruction sheet for Resident #1. The narcotic logbook had an X through the page for Oxycodone 5 mg-½ tablet twice a day: with 14 tablets remaining. This would indicate resident #1 Oxycodone was discontinued, however, there were no licensed staff signatures on the page to determine that staff discontinued the medication. The narcotic destruction sheet contained an entry for Resident #1's Oxycodone 2.5 mg 14 tablets destroyed with the AP's signature and an illegible second witness signature.

Additional facility investigation indicated Resident #2's narcotic logbook contained four pages of Oxycodone, one tablet every six hours prn, with each page accounting for 30 tablets or 120 tablets total. Each page had a X across the entire page with discontinued on the bottom of each page. There were no licensed staff signatures on the page to determine the staff that discontinued the Oxycodone. The narcotic destruction sheet contained an entry for Resident #2's Oxycodone and indicated 130 tablets (not the actual 120 tablets) were destroyed and signed by the AP with an illegible witness signature.

The facility investigation indicated Resident #3's narcotic record contained a page for Percocet 5-325 mg every four hours prn with 18 tablets remaining. The logbook entry had an X across the page without a discontinued date or licensed staff signatures to determine the staff that

discontinued the medication. Resident #3's narcotic destruction sheet entry contained Percocet 18 tablets destroyed with the AP's signature and an illegible witness signature.

During interview, management stated during the facility investigation into the incident, all involved licensed staff were interviewed, and the witness signatures on the destruction sheets were compared to staff signatures. No identifying staff, including pool staff, matched the witness signature on the AP's destruction entries. Management stated despite reminders, the AP failed to complete the new hire training for medication administration that included the facility policy and procedures regarding discontinuation and reconciliation of narcotic medications.

During interview, the AP denied diverting the narcotic medications, and stated the entries on the destruction sheets were witnessed by a second licensed staff but he was not able to identify the witness. The AP stated he was not trained on the facility's policies and procedures for narcotic medication administration.

Review of the AP's personnel file confirmed there was no evidence the facility provided the AP with training on medication discontinuation and reconciliation of narcotic medications.

In conclusion, it was inconclusive whether exploitation by drug diversion occurred.

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

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No. Resident #1 and Resident #2 not able to be interviewed. Resident #3 passed away.
Family/Responsible Party interviewed: Yes, attempted for Resident #1 and Resident #2. The incident occurred after Resident #3 passed away.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Management reviewed the policies and procedures for medication administration including discontinuation and reconciliation of narcotic medications and provided staff training. Management completed an audit on all residents' narcotic medication to ensure compliance. With any discontinued narcotic medication, the witness must be the facility Director of Nursing. The facility no longer employed the AP.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc: The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 04/15/2022

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) COMPLETE DATE
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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5258062M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 04/15/2022

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) COMPLETE DATE
2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		