Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2026

Administrator
Franciscan Health Center
3910 MINNESOTA AVENUE
DULUTH, MN 55802

RE: CCN: 245258

Cycle Start Date: January 29, 2026

Dear Administrator:

On March 25, 2026, we notified you a remedy was imposed. On May 1, 2026, the Minnesota Departments of Health and Public Safety 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 April 28, 2026.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective April 29, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 25, 2026, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years fromApril 29, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 28, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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March 25, 2026

Administrator
Franciscan Health Center
3910 MINNESOTA AVENUE
DULUTH, MN 55802

RE: CCN: 245258
Cycle Start Date: January 29, 2026

Dear Administrator:

On February 11, 2026, we informed you that we may impose enforcement remedies.

On February 27, 2026, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 29, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 29, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 29, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343, 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.

If you have not achieved substantial compliance by April 29, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Franciscan Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 29, 2026.  You will receive further information regarding this from the State agency.  This prohibition is not subject to appeal.   Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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 an "E"tag), i.e., the plan of correction should be directed to:


**Alex Warren, Regional Operations Supervisor**
**Duluth District Office**
**Health Regulation Division**
**Minnesota Department of Health**
**11 East Superior Street, Suite 290**
**Duluth, MN 55082**
**Email: Alex.Warren@state.mn.us**

**Cell: 651-279-5375 Office: 218-302-6186**


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 - Health Regulation Division 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 July 29, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

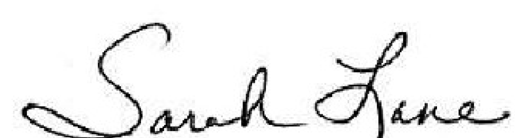
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245258** | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED **02/27/2026** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Franciscan Health Center** | **3910 MINNESOTA AVENUE , DULUTH, Minnesota, 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 |
|---|---|---|---|---|
| E0000 | Initial Comments<br><br>On 2/23 to 2/27/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E0000 | | 04/28/2026 |
| F0000 | INITIAL COMMENTS<br><br>On 2/23 to 2/27/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: H52586642C (2743659) and H52586868C (2784468). NO deficiencies were cited.<br><br>The following complaints were reviewed: H52586641C (2730023) and H52586640C (2664942) with deficiencies cited at F684 and F725.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F0000 | | 04/28/2026 |

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 reverse for further 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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| F0000 | Continued from page 1<br>The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. | F0000 | | |
| F0628<br>SS = A | Discharge Process<br><br>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii)<br><br>§483.15(c)(2) Documentation.<br><br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br><br>(iii) Information provided to the receiving provider must include a minimum of the following:<br><br>(A) Contact information of the practitioner responsible for the care of the resident.<br><br>(B) Resident representative information including contact information<br><br>(C) Advance Directive information<br><br>(D) All special instructions or precautions for ongoing care, as appropriate.<br><br>(E) Comprehensive care plan goals;<br><br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br><br>§483.15(c)(3) Notice before transfer.<br><br>Before a facility transfers or discharges a resident, the facility must-<br><br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the | F0628 | | 04/28/2026 |

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| F0628<br>SS = A | Continued from page 2<br>State Long-Term Care Ombudsman.<br><br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br><br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br><br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br><br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br><br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br><br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br><br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br><br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br><br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br><br>(i) The reason for transfer or discharge;<br><br>(ii) The effective date of transfer or discharge;<br><br>(iii) The location to which the resident is transferred or discharged;<br><br>(iv) A statement of the resident's appeal rights, | F0628 | | |

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| F0628<br>SS = A | Continued from page 3<br>including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br><br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br><br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the | F0628 | | |

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| F0628<br>SS = A | Continued from page 4<br>resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br><br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br><br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br><br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1 ) of this section, permitting a resident to return; and<br><br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br><br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br><br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure a resident being transferred to the hospital was given a bed hold notice for 1 of 1 | F0628 | | |

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| F0628<br>SS = A | Continued from page 5<br>resident (R1) reviewed for hospitalization.<br><br>Findings include:<br><br>R1's quarterly minimum data set (MDS) dated 1/5/26, identified intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, diabetes mellitus, palliative care, anxiety disorder, dementia, and congestive heart failure (CHF).<br><br>R1's electronic medical record (EMR) identified a hospitalization on 10/15/25. R1's EMR didn't contain a notice of bed hold as a scanned form, nor did it contain a progress note indicating a bed hold was given or discussed with R1 or their family.<br><br>During an interview on 2/26/26 at 9:33 a.m., social services designee (SS)-A stated the normal process was for the health unit coordinator (HUC) to scan the bed hold notice to the computer and then scan a copy to her. SS-A confirmed they couldn't locate a bed hold for R1's 10/15/25 hospitalization.<br><br>During an interview on 2/26/26 at 1:20 p.m., the acting director of nursing (DON) stated anytime a resident was transferred out of the facility they needed to have a bed hold signed or to get verbal consent from family depending on the situation. The DON confirmed R1's EMR didn't contain evidence of a bed hold.<br><br>A policy, Bed Hold Election & Hospital Transfer dated 9/3/25, identified the policy purpose was to ensure residents and/or representatives understand their rights regarding bed hold options. For a hospitalization leave, if a resident is admitted to the hospital and is expected to return, the care center will provide a bed hold policy and election consent. The policy didn't address documentation. | F0628 | | |
| F0641<br>SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. | F0641 | F: 641 It is Franciscan Health Center's policy to have accurate MDS coding.<br><br>The Director of Nursing will implement corrective action for residents R3, R12 and R15 affected by this practice by:<br><br>Resident R3 MDS assessment was reviewed in comparison with the electronic medical record (EMR), wound portal, and wound nurse documentation. Discrepancies related to pressure ulcer staging and present-on-admission status were identified and corrected. A modification of the MDS was submitted to ensure accurate coding of | 04/28/2026 |

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| F0641<br>SS = D | Continued from page 6<br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure accuracy of the minimum data set (MDS) was coded accurately for 3 of 14 residents (R3, R12, R15) reviewed for MDS accuracy.<br><br>Findings include:<br><br>R3:<br><br>R3's significant change in status assessment (SCSA) minimum data set (MDS) dated 2/6/26, identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition. The MDS identified R3 was at risk for and had actual PUs including a stage three and an unstageable deep tissue injury, both were identified as present on admission.<br><br>R3's quarterly MDS dated 12/10/25, identified R3 was at risk for and had an actual stage three pressure ulcer (PU) that was not present on admission.<br><br>R3's admission MDS dated 9/22/25, identified R3 was not at risk for and didn't have any actual PUs. Further, | F0641 | Continued from page 6<br>in-house acquired wounds.<br><br>Resident R12 MDS assessment was reviewed against physician orders, medication administration records (MAR), and diagnosis documentation. Discrepancies in Section N (antipsychotic medication use and indication) were identified and corrected. The MDS was modified to accurately reflect medication use.<br><br>Resident R15 MDS assessment was reviewed against physician orders, care plan, and resident interview confirming CPAP use. Section O coding was corrected to reflect CPAP use during the look-back period. A modified MDS was submitted.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents who have mobility rails for turning and repositioning have the potential to be affected by this practice.<br><br>An audit of MDS assessments completed within the past 30 days will be conducted for all current residents, with focused review on: Pressure ulcer/injury coding and present-on-admission status, Section N medication coding, specifically antipsychotic use and indication, Section O special treatments, including CPAP use. Any discrepancies identified will be reviewed by the interdisciplinary team and corrected in accordance with MDS submission guidelines.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>The MDS nurse and interdisciplinary team members involved in assessment documentation will be re-educated on accurate MDS coding requirements, with emphasis on: Pressure ulcer/injury coding and present-on-admission status, Section N high-risk medication coding consistency, Section O coding for special treatments and devices such as CPAP.<br><br>A pre-submission MDS accuracy review process will be implemented for targeted sections, including comparison of MDS coding against physician orders, MAR/TAR, care plans, wound documentation, and clinical interview/documentation. | |

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| F0641<br>SS = D | Continued from page 7<br>the MDS identified a formal assessment tool (i.e., Braden Scale) was not performed. R3's care area assessment (CAA) dated 9/22/25, identified the pressure ulcer care area and care planning decision were triggered.<br><br>R3's care plan didn't contain a focus statement for at-risk or actual skin impairment. On 9/19/25, R3's care plan had a focus statement for activities of daily living (ADL) self-care performance deficit related to CVA with an intervention for staff assist of one to turn and reposition every two hours and as needed and preferred not to be woken at night.<br><br>A Braden Scale for Predicting Pressure Sore Risk performed on 9/19/25, identified R3's score was 17, which correlated to an at-risk category.<br><br>The wound portal in R3's electronic medical record (EMR) identified a new in-house acquired stage three pressure ulcer at the right dorsum, fourth interdigital space on 12/10/25. A new in-house acquired unstageable pressure injury to the front right trochanter (hip) on 1/7/26.<br><br>During an interview on 2/26/26 at 3:57 p.m., registered nurse (RN)-D stated they were the MDS nurse, and she would say the information in section M of the 2/6/26 MDS was an error. RN-D stated the error would affect reimbursement.<br><br>R12:<br><br>R12's significant change MDS dated 1/30/26, identified R12 had diagnoses which included malignant neoplasm of right renal pelvis, hypothyroidism, dementia, and hypertension. In addition, R12's MDS identified they were severely cognitively impaired.<br><br>"Section N Medications: High-Risk Drug Classes: Use and Indication Antipsychotic: is taking", this was marked as yes.<br><br>The section "Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?" This was marked as not necessary, marked as not on an antipsychotic.<br><br>R12's current order summary identified the following:<br><br>Observe closely for side effects of antipsychotic medication dated 10/27/25. | F0641 | Continued from page 7<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Audits will be conducted beginning the week of 4/13/26 The DON, MDS Coordinator, or designee will audit: 5 MDS assessments per week for 4 weeks, Then 3 MDS assessments per week for 4 weeks, Then 2 MDS assessments monthly for 2 months. Audits will include review of Sections M, N, and O, and comparisons to support clinical documentation, physician orders, care plans, and treatment records. Any concerns identified will be corrected promptly and additional training provided as needed.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0641<br>SS = D | Continued from page 8<br>Olanzapine (an atypical antipsychotic medication) 15 milligrams (mg) dated 1/13/26<br><br>R12's care area assessment dated 1/30/26, identified the following:<br><br>Section N-Medications N0415, identified R12 was taking an antipsychotic<br><br>Section N- Medications N0450, identified R12 was receiving antipsychotics on a routine basis only. It was marked as no a gradual dose reduction had not been attempted.<br><br>During an interview on 2/25/26 at 1:31 p.m., registered nurse (RN)-D reviewed the MDS dated 1/30/26, and verified it contained contradictory information. RN-D stated it was a "glitch" and the MDS would need to be modified. RN-D verified it was important to ensure accuracy for pharmacy review to ensure the need for the medication and to monitor if it was working.<br><br>R15:<br><br>The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2025, identified Section O0110G3: Non-invasive Mechanical Ventilator – CPAP, code any type of CPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously throughout the breathing cycle.<br><br>R15's annual Minimum Data Set (MDS) dated 2/11/26, indicated R15 was cognitively intact. Section O: Special Treatments, Procedures, and Programs, question O0110G3 identified R15 had not received CPAP in the last 14 days.<br><br>R15's facesheet included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea.<br><br>R15's care plan revised 11/24/25, included CPAP settings.<br><br>R15's current provider orders dated 2/27/26, included:<br><br>CPAP: staff to set up at HS (bedtime) and when in bed for naps. every shift Startup CPAP as machine is preprogrammed and will adjust to inhalation pressure needs | F0641 | | |

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| F0641 SS = D | Continued from page 9<br><br>R15's treatment administration record (TAR) for the months of 12/2025, 1/2026, and 2/2026 instructed staff to set up the CPAP nightly and as needed for naps. Staff documented daily use of CPAP for the 3 months reviewed.<br><br>During an interview on 2/23/26 at 12:33 p.m., R15 stated they used their CPAP every night.<br><br>During an interview on 2/27/26 at 11:03 a.m., RN-D reviewed the MDS dated 2/11/26, and confirmed it did not contain coding for R15's use of CPAP. They stated it should be coded if the resident is using it. After reviewing R15's record, RN-D confirmed that the CPAP should have been coded on the MDS.<br><br>A facility policy MDS 3.0 Completion dated 8/20/24, instructed that all MDS item sections were to be reviewed to develop an interdisciplinary care plan. The MDS Coordinator was responsible for conducting audits to identify errors to ensure accuracy of information, and they needed to sign and date the assessment upon completion. | F0641 | | |
| F0645 SS = D | PASARR Screening for MD & ID<br><br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br><br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br><br>(ii) Intellectual disability, as defined in paragraph | F0645 | F: 645 It is Franciscan Health Center's policy have completed PASARR Screenings for MD & ID CFR(s) upon admission into Skilled nursing facility.<br><br>The Director of Social Service will implement corrective action for residents R8 affected by this practice by:<br><br>R8 had updated PASARR completed to review level of care and screening for MD and ID to determine continuation of appropriate placement in SNF on 03/06/26.<br><br>The Director of Social Service will assess residents having the potential to be affected by this practice including:<br><br>All residents who reside at the facility have the potential to be affected by this deficient practice.<br><br>The Director of Social Service will implement measures to ensure that this practice does not recur including: | 04/28/2026 |

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| F0645<br>SS = D | Continued from page 10<br>(k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br><br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br><br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br><br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br><br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br><br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.<br><br>§483.20(k)(3) Definition. For purposes of this section-<br><br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br><br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0645 | Continued from page 10<br>The PASARR will be indicated as completed prior to admission into facility<br><br>The PASARR will have appropriate follow-up from indicated agencies on PASARR (ex: County) which will be kept on file along with PASARR.<br><br>All residents who reside at the facility will have PASARR's reviewed for appropriate completion.<br><br>The Social Service Director and nursing leadership /have been educated on PASARR requirements, including Identification of MI/ID triggers, requirement for OBRA Level II evaluation completion.<br><br>The interdisciplinary team will review PASARR status during admission review and care planning processes to ensure compliance and appropriate service provision.<br><br>The Director of Social Service will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Social Services Director or designee will audit all new admissions for PASARR compliance (Level I and Level II, if triggered) starting 4/13/26; weekly for 4 weeks, then monthly for 2 months.<br><br>Audits will include verification that: Level I screenings are complete and accurate, Level II referrals are made when indicated, Level II determinations are obtained and implemented.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0645<br>SS = D | Continued from page 11<br><br>Based on interview and document review, the facility failed to ensure an OBRA Level II evaluation was completed as identified on the pre-admission screening to ensure mental health needs were appropriately addressed or provided for 1 of 1 resident (R8) reviewed for preadmission screening and resident review (PASRR).<br><br>Findings include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 1/7/26, identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living.<br><br>R8's corrected preadmission screening dated 10/14/25, identified they required an OBRA Level II screening for mental illness. The question, "Is an OBRA Level II referral needed and is the person currently seeking admission to a nursing facility?" The question was answered as yes.<br><br>During an interview on 2/24/26 at 10:44 a.m., social service designee (SSD)-A stated R8 came from a different facility. SSD-A stated she was not sure if an OBRA Level II was completed and would check. The facility was not able to provide evidence this was completed prior to admission, nor was there evidence this was completed after admission to the facility.<br><br>During an interview on 2/27/26 at 11:01 a.m., the acting director of nursing (ADON) stated they were not familiar with the OBRA Level II process and would defer this to the SSD.<br><br>Pre-Admission Screening & Resident Review (PASRR) dated 6/25/24, identified the following, "If a mental illness or development disability is identified, an additional screening, referred to as a PASRR Level II screening is required". | F0645 | | |
| F0657<br>SS = D | Care Plan Timing and Revision<br><br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment. | F0657 | F: 657 It is Franciscan Health Center's policy to update our residents care plan as needed.<br><br>The Director of Nursing will implement corrective action for residents R3 affected by this practice by:<br><br>The interdisciplinary team (IDT) immediately reviewed and updated the comprehensive care plan to accurately reflect: Current skin impairment risk and | 04/28/2026 |

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| F0657<br>SS = D | Continued from page 12<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to update the plan of care to reflect changes in resident's needs related to the risk of, and actual, skin impairment, to reflect interventions after a fall, to reflect current elopement risk and interventions, to individualize pain management, and to accurately reflect the resident's current mobility status for 1 of 13 residents (R3) reviewed for care planning timing and revision.<br><br>Findings include:<br><br>R3's significant change in status assessment (SCSA) minimum data set (MDS) dated 2/6/26, was performed following a hospice admission on 1/30/26, and identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition, a stage three pressure ulcer, and an unstageable deep tissue wound. R3 had a functional limit in range of motion upper and lower body on one side and was dependent with toilet hygiene, lower body dressing, and transfers. R3 needed maximal assistance with bed mobility and set-up assistance to wheel themselves in a wheelchair for 50 and 150 feet. | F0657 | Continued from page 12<br>interventions, post-fall interventions and monitoring, Elopement risk and prevention strategies, Individualized pain management approaches, Current mobility status and required assistance, Implementation of a care plan update trigger system during daily IDT for care plans requiring review/revision within 24–48 hours after significant change.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents have the potential to be affected by this practice.<br><br>The DON, Nurse Managers, and/or designee completed: An audit of current residents' care plans to ensure: Care plans reflect current condition, risks, and interventions, Updates were completed timely after significant changes (falls, skin issues, behavior changes, mobility changes)<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>An audit of dependent residents requiring assistance with ADLs (toileting, repositioning, incontinence care) to ensure: Care plans reflect required level of assistance, Staff are following interventions as written, Skin integrity documentation, weekly skin checks, and incident reports were reviewed to ensure appropriate follow-up and care plan revisions. Any identified gaps were corrected immediately, including updating care plans and initiating interventions.<br><br>Skin Integrity policy reviewed on 3/26/26 with no changes made. All licensed nurses will be educated on the Skin Integrity Policy.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Audits will be completed beginning the week of 4/13/26, Nurse Managers/designees will complete: Care Plan Audits: Weekly audits x 4 weeks, then, Monthly audits x 2 months to ensure: Care plans are updated timely after changes, Interventions are individualized | |

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| F0657<br>SS = D | Continued from page 13<br>The MDS also reflected R3 had a wander or elopement alarm used daily.<br><br>R3's care plan identified:<br><br>-a revision on 2/20/26, identified a focus statement for risk for falls with interventions dated 9/19/25 to assist resident with ambulation and transfers utilizing therapy recommendations, to determine resident's ability to transfer, and if resident is a fall risk, initiate fall precautions.<br><br>-a revision on 2/20/26, a focus statement for limited physical mobility related to stroke with interventions dated 9/18 and 9/19/25, to utilize foot pedals on the right side of the wheelchair only to and from destinations; resident able to propel the wheelchair with his left foot, to work on ambulation with therapy only at this time, assist with propelling wheelchair as needed, and to monitor, document, and report any signs or symptoms of immobility, contractures, thrombus formation, skin breakdown or fall-related injury.<br><br>-a revision on 2/20/26, a focus statement for at risk for falls related to gait and balance problems with interventions dated 9/15/25 to ensure call light in reach and encouragement to use the call light, to educate resident, family and caregivers about safety reminders and what to do if a fall occurs, to encourage resident to participate in activities that promote exercise, physical activity for strengthening and mobility improvement, to ass fall risk quarterly and with changes in condition, to provide resident with easy access to a urinal, provide verbal cues and reminders as needed, and for physical therapy as ordered or as needed. On 11/14/25, the interventions were updated to include ensuring resident had a large, covered mug with fresh water in room in the morning, bedtime, and as needed. On 1/14/26, an intervention to offer to get R3 up for the day at around 7:30 a.m. The care plan didn't contain an intervention for the fall of 2/22/26.<br><br>-a revision on 2/20/26, a focus statement for acute and chronic pain with interventions dated 11/8/25 to determine resident's satisfactory pain level, to evaluate mood and behavior, and to monitor for factors or activities that precipitate or aggravate pain.<br><br>-R3's care plan didn't contain a focus statement, goals or interventions for wandering, elopement and the use of an elopement alarm.<br><br>-R3's care plan didn't contain a focus statement, goals | F0657 | Continued from page 13<br>and accurate, ADL & Skin Integrity Audits, Weekly observational audits x 4 weeks, then Monthly audits x 2 months to ensure: Timely toileting/incontinence care, Staff adherence to care plans, Completion of weekly skin checks.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0657 SS = D | Continued from page 14 | F0657 | | |

or interventions for actual skin impairment.

An elopement assessment dated 9/15/25, identified R3 wasn't physically immobile, did display wandering and hovering around exits, and made statements of wanting to go home. A wander guard was placed on 9/15/25.

An elopement assessment dated 2/6/26, identified R3 didn't have a wander guard in place as resident was unable to propel himself in his wheelchair and was not at risk for elopement at this time.

R3's electronic medical record (EMR) identified post-fall evaluations on 11/8/25, 1/3/26, and 2/22/26.

During an observation on 2/23/26 at 2:20 p.m., R3 had a non-removable white bracelet on the left wrist.

During an observation on 2/26/26 at 10:47 a.m., nursing assistant (NA)-B confirmed the device on R3's left wrist was a wander guard.

During an interview on 2/27/26 at 12:46 p.m., the director of nursing (DON) stated her expectation would be for the care plan to reflect R3's needs.

A policy, Person Centered Care Planning dated 4/20/23, identified the facility will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in our care center, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The plan of care will describe the following:

a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

b. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment, and any alternative means to address the need.

c. Management of risk factors and prevent avoidable declines in functioning.

The resident's care plan is reviewed every 90 days or more frequently if necessary, with a significant change. Care plans are updated on an ongoing basis as needed based on changes that occur between care conferences.

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| F0657 SS = D<br>F0677 SS = D | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based observation, interview and document review the facility failed to provide timely assistance with checking and changing for 1 of 1 resident (R8) reviewed for activities of daily living and who were dependent on staff for assistance.<br><br>Finding include:<br><br>R8's quarterly Minimum Data Set (MDS) dated 1/7/26, identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, history of urinary tract infections, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living and was always incontinent of bowel and bladder.<br><br>A review of R8's current order summary report included the following orders:<br><br>One half vinegar one half water solution soak two times a day, soak right abdominal groin folds and under both breasts for 10 minutes with solution, pat dry, apply zinc cream, dated 2/26/26.<br><br>Skin charting one time a day every Saturday complete weekly per schedule, dated 11/22/25.<br><br>Myrbetriq (medication used to treat overactive bladder) oral tablet extended release 24 hour 60 milligrams (mg) one time a day related to stress incontinence, dated 10/11/25.<br><br>R8's history order summary report included the following orders:<br><br>Nystatin external powder 100000 unit per gram (GM) apply to affected areas tropically as needed for two times a day apply to abdominal folds, groin, under breasts, dated 10/10/25.<br><br>Monitor and document signs and symptoms of urinary tract infection and vitals every shift, document in | F0657<br>F0677 | F: 677 It is Franciscan Health Center's policy to provide ADL care for dependent residents per our resident's plan of care.<br><br>The Director of Nursing will implement corrective action for residents R8 affected by this practice by:<br><br>Resident R8's care plan, Kardex, was reviewed and updated to reinforce the requirement for checking and changing every 2 hours and as needed, while honoring the resident's preference not to be awakened before 9:00 a.m. unless care needs require earlier intervention. Staff were re-educated that resident preferences do not override the need to provide necessary ADL care, skin protection, and incontinence care to prevent skin breakdown, discomfort, and infection risk. Weekly skin checks for R8 were reviewed for accuracy and completion, and the resident was placed under monitoring to ensure timely incontinence care, treatment completion, and skin follow-up.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents who are dependent on ADL's have the potential to be affected by deficient practice.<br><br>A facility-wide audit was conducted for residents who are: Dependent on ADLs, frequently incontinent, on toileting programs, The audit included: Review of care plans, Observation of care delivery, Documentation of toileting and brief checks. Any identified concerns were addressed immediately, including updating care plans. Development of a standardized ADL care checklist for CNAs to ensure completion of: Toileting, Brief checks/changes, Skin observation, Reinforcement of balancing resident preferences with clinical needs, ensuring care is provided promptly once the resident is awake or requests assistance.<br><br>Skin Integrity policy reviewed with changes made. Nurse Managers will conduct routine rounding and direct observation of care delivery. Reinforcement of accountability for missed or delayed care.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including: | 04/28/2026 |

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| F0677<br>SS = D | Continued from page 16<br>progress notes, started on 1/26/25.<br><br>R8's care plan dated 10/10/25, identified R8 had an activity of daily living deficit related to activity intolerance, impaired balance. Interventions included a toileting schedule every two to three hours and per their request. The care plan identified "frequently incontinent of bowel and bladder". In addition, bowel incontinence related to immobility. Interventions included to check every two hours and assist with toileting as needed.<br><br>R8's care plan dated 10/10/25, identified R8 was at risk for insomnia. Interventions included to maintain a consistent schedule with daily routine.<br><br>R8's care plan dated 1/7/26, identified R8's personal care preferences. Interventions included, "I prefer to be woken around and be out of bed after 9:00 a.m. Do not wake me up before 9:00 a.m."<br><br>A review of R8's weekly skin assessments revealed the following:<br><br>2/21/26, moisture documented as "normal", noted "No, there are no skin concerns."<br><br>1/24/26, (about a month earlier) moisture documented as "normal", noted "No, there are no skin concerns."<br><br>1/21/26, moisture documented as "normal", noted "No, there are no skin concerns."<br><br>1/6/26, (about two weeks earlier) documented as "other" quarterly MDS.<br><br>Skin group page 18 documented as "No skin issues" further pages identified perineum, right breast, left breast, "rash" all documented as resolved.<br><br>12/10/25, (about 4 weeks earlier) moisture documented as "normal", noted "No, there are no skin concerns."<br><br>12/2/25, moisture documented as "normal", noted "No, there are no skin concerns."<br><br>11/29/25, moisture documented as "normal", noted "No, there are no skin concerns."<br><br>10/14/25, (about 6 weeks earlier) moisture documented as "normal"<br><br>10/10/25, admission skin assessment, left and right breast, perineum rash, present on admission, chronic | F0677 | Continued from page 16<br><br>Audits will be completed beginning the week of 4/13/26, Nurse Managers/designees will complete: Weekly audits x 4 weeks, then Monthly audits x 2 months. Audits will include Timeliness of toileting and incontinent care, documentation of checks/changes, Skin condition monitoring, random direct observation audits will also be conducted. checking/changing is completed timely per care plan and resident need, weekly skin checks are completed as scheduled, refusals are documented and appropriately followed up, new or worsening skin concerns are reported and addressed promptly. .<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0677 SS = D | Continued from page 17 | F0677 | | |

greater than 3 months.

A review of R8's progress notes revealed the following:

2/24/26, 3:32 p.m., "Writer asked to assess resident skin under breasts and abd (abdominal)/groin folds. Skin condition not improving with current treatment of Nystatin powder. Writer called Dr. XXXXX and received new order as follows: Soak right abdominal/groin folds and under both breasts for 10 minutes with 1/2 vinegar 1/2 water solution. Pat dry. Apply Zinc cream. Twice daily. Writer also discussed adding resident to list for wound care NP to see."

2/10/26, 10:47 a.m., New orders from MD "Please keep pt (patient) dry r/t (related to) recurrent UTIs (urinary tract infections)."

A continuous observation started on 2/25/26 at 7:05 a.m. and ended at 11:01 a.m., four hours. At the beginning of the observation R8's door was closed and the lights in the hallway were dim. No staff were observed going into R8's room during the four-hour window.

On 2/25/26 at 11:01 a.m., nursing assistant (NA)-B knocked and entered R8's room. R8 gave permission to observe cares. NA-B left the room to get the nurse for "some skin issues".

-at 11:15 a.m., registered nurse (RN)-E entered the room, performed hand hygiene, put on gloves and opened R8's brief. R8's skin was bright red in groin area (both sides), extending across her abdomen under pannus (hanging, apron-like layer of skin and fat that sags over the lower abdomen and pubic region). The bright red skin extended from one to four inches in groin and pannus areas. Under R8's breasts the skin was bright red with the redness extending two to three inches under breasts. RN-E told R8 the treatment with nystatin was not working and her provider changed the treatment order, RN-E told her it was a vinegar and water mixture and "it might sting".

-at 11:28 a.m., R8 was rolled to her left side, the brief was soaked yellow from urine and R8 had a moderate amount of formed brown stool in her brief and stuck to her skin. R8's skin was intact on her buttocks. A new brief was positioned under R8.

-at 11:35 a.m., RN-E returned to finish the treatment process. She removed the 4x4's, dried R8's skin, and put on the new skin treatment, she told R8 what she was doing and asked her if it was hurting. R8 periodically

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| F0677<br>SS = D | Continued from page 18<br>would answer yes or wince.<br><br>-at 11:43 NA-B asked R8 if she had wanted to be woken up earlier, R8 responded with “yes, wake me up”.<br><br>During an interview on 2/23/26 at 1:41 p.m., R8 stated she sometimes had to wait two hours to get the call light answered. R8 stated one night she was left “wet” all night until the next morning.<br><br>During an interview on 2/24/26 at 10:25 a.m., R8 was dressed for the day and seated in her wheelchair in her room. R8 stated she liked to get up about 9:00 a.m.”<br><br>During an interview on 2/25/26 at 11:00 a.m., nursing assistant (NA)-B stated R8 had last been checked and changed at 6:30 a.m., by the night shift. NA-B stated she was aware R8 liked to be up around 9:00 a.m. and stated it had been too long to go without checking for incontinence. NA-B stated they were “down” one nursing assistant and were sometimes short. NA-B stated they were taking care of 14 residents by themselves.<br><br>During an interview on 2/26/26 at 1:18 p.m., RN-A reviewed R8’s care plan and stated R8’s preference was to be up after 9:00 a.m. RN-A verified four hours was too long to go without checking for incontinence and changing a resident’s brief. RN-A stated R8 was having moisture related skin concerns, said it might be related to incontinence. RN-A reviewed the note from the provider to keep resident dry related to recurrent urinary tract infections. RN-A stated they had been treating the redness in her groin and under her breasts since October 2025.<br><br>During an interview on 2/27/26 at 9:40 a.m., RN-A reviewed R8’s skin assessments and verified they were being documented as moisture “normal” and “no skin concerns”. RN-A verified there were gaps sometimes as long as month with no skin assessment documented as completed. RN-A stated the expectation was skin checks would be completed weekly to monitor skin and keep track of any skin problems.<br><br>During an interview on 2/27/26 at 10:59 a.m., the acting director of nursing (acting DON) stated it was the expectation the skin checks would be completed weekly on the shower day. The acting DON stated if the resident refused their shower, it was still the expectation the skin checks would be completed. If the resident refused the skin checks, the expectation would be for the nurse to re-approach and notify the nurse manager of the refusal. Weekly skin checks were important to look for skin breakdown. The acting DON | F0677 | | |

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| F0677<br>SS = D | Continued from page 19<br>stated checking and changing was also important to complete as identified in the care plan, again stated the purpose was to prevent skin breakdown.<br><br>During an interview on 2/27/26 at 1:47 p.m. licensed practical nurse (LPN)-B stated they had finished R8's treatment and noted skin under breasts was "pink", in the groin area "bright red". LPN-B stated R8's skin looked improved from the previous week. LPN-B stated R8 said it burned a little during the treatment.<br><br>Skin Integrity dated 5/21/25, identified "nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice." In addition, the policy identified skin checks would be completed weekly by a licensed nurse and the provider would be notified of any significant changes or a delay in healing. The policy further identified skin issues would be tracked, trended and reported at the Quality Assurance Performance Improvement meetings to determine if corrective action needed to be taken. | F0677 | | |
| F0684<br>SS = D | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure a wound bed was protected in a resident at risk for cross contamination due to incontinence for 1 of 1 resident (R6) whose cares were observed.<br><br>Findings include:<br><br>Review of R6's quarterly Minimum Data Set (MDS) dated 1/21/26, identified R6 as moderately cognitively impaired.<br><br>R6's face sheet, undated, included diagnoses of stage 4 pressure ulcer left buttock, congestive heart failure (CHF), and venous insufficiency. | F0684 | F: 684 It is Franciscan Health Center's policy to provide residents with proper interventions in regard to skin care<br><br>The Director of Nursing will implement corrective action for resident R6 affected by this practice by:<br><br>Treatment to R6 pressure ulcer to left buttocks will be reviewed with the Provider and orders updated as needed.<br><br>Licensed Nurses to be educated on treatment to R6 pressure ulcer to left buttocks, including replacing treatment if it has become loose, removed, or soiled.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents who have pressure ulcers have the potential to be affected by this deficient practice.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including: | 04/28/2026 |

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| F0684<br>SS = D | Continued from page 20<br><br>R6's care plan revised 11/24/25, instructed the following:R6 required assistance of two when repositioned and when transferred with full sling mechanical liftuse Enhanced Barrier Precautionsmonitor dressing to ensure it is intact and adhering and report lose dressing to treatment nurseprovide skin care per facility guidelineswound care per treatment order of specialized practitioner for wound managementR6's current provider orders dated 2/27/26 included:PU (pressure ulcer) to left buttock: as needed for if dressing soiled, came off during cares/shower, etc. Staff to use foot cradle in bed. Encourage Frequent offloading Q 2hrs (every 2 hours) and up in chair daily for 2 hrs.PU to left buttock: every evening shift related to pressure ulcer of left buttock, stage 4 WC (wound care) to wound bed, ¼ strength Dakins packing (apply kerlex gauze and pack wound), cover with bordered foam to secure daily and prn (as needed), Encourage frequent offloading every 2 hours and up to chair daily for 2 hours.R6's Integrated Wound Care (IWC) progress notes dated 2/23/26, identified pressure wounds to left buttock, left heel, and right ankle. It also identified frequent incontinence of bowel and bladder results in difficulty with healing.<br><br>R6's treatment administration record (TAR) dated 2/27/26, instructed staff to provide wound care to left buttock wound every evening shift, packing the wound and covering with bordered foam to secure daily and as needed if soiled or change off in shower etc.<br><br>During an observation on 2/25/26 at 12:49 p.m., nursing assistant (NA)-A and registered nurse (RN)-B changed R6's brief. NA-A told RN-B that R6 had no dressing on their left buttock wound. RN-B motioned to continue with brief change. The wound had packing and the brief was saturated, no stool, and there was a baseball-sized amount of light yellow-brown drainage where brief aligned wound. NA-A cleansed R6's skin and replaced their brief. No dressing was applied to the left buttock wound.<br><br>During an interview on 2/25/26 at 1:55 p.m., RN-B confirmed that R6's left buttocks wound dressing was not in place when they changed R6's brief. They stated they would need to check the order as orders may have changed, and they thought a previous order was to keep the wound open to air. They stated they would review the orders and either do the dressing before the end of their shift or pass it on to the next nurse as a priority.<br><br>During an interview on 2/25/26 at 3:28 p.m., licensed | F0684 | Continued from page 20<br>The Skin Integrity Policy was reviewed on 3/26/26 with no changes needed.<br><br>All licensed nurses will be educated on the Skin Integrity Policy. Education will include that all residents with pressure ulcers need to have treatment in place per order and that dressings help protect wound beds from cross contamination related to incontinence depending on the location of the wound.<br><br>All residents with pressure ulcers will have their treatment orders reviewed to ensure appropriate.<br><br>All NARs will be educated on reporting to the licensed nurse if a residents' dressing has become loose, removed, or soiled.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Audits will be completed Beginning the week of 4/13/26 random observational audits will be conducted to ensure pressure ulcer treatment(s) are in place per order; 3x/week x 2 weeks, 2x/week x 2 weeks, 1x/week x 1 week, until compliance is achieved.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0684 SS = D | Continued from page 21<br>practical nurse (LPN)-A stated R6's uncovered left buttock wound was passed off to them during shift report from RN-B. They stated they planned to replace the dressing in a few hours but had other priorities first. LPN-A reported that R6 often had multiple stool incontinence episodes per shift. They confirmed concern for infection prevention with the wound being open to the brief.<br><br>During an interview on 2/26/26 at 2:57 p.m., acting director of nursing (DON) stated they expected staff to notify the nurse if there was no dressing on a wound, and they expected nurses changed dressings as needed for soiled or excessive drainage. Acting DON confirmed their concern for infection control because R6's incontinence of bowel and bladder put them at risk for contamination of the wound bed.<br><br>The facility policy Skin Integrity revised 5/21/25, directed staff to evaluate the status of the wound dressing and notify the nurse manager if the dressing was not intact or drainage was present. | F0684 | | |
| F0686 SS = D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br><br>§483.25(b)(1) Pressure ulcers.<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure ongoing skin inspections, wound assessments, and timely repositioning were performed for a resident with pressure ulcers for 1 of 2 residents (R3) reviewed for pressure ulcer care. These failures resulted in the development of facility-acquired pressure ulcers and placed the | F0686 | F: 686 It is Franciscan Health Center's policy to provide treatment/services to prevent/heal pressure ulcers.<br><br>The Director of Nursing will implement corrective action for resident R3 affected by this practice by:<br><br>R3's treatment orders were reviewed and updated in collaboration with the provider to ensure appropriate management of stage III pressure ulcer and unstageable deep tissue injury.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents at risk of pressure ulcers have the potential to be affected by this deficient practice.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>A facility-wide audit was conducted for all residents with: Pressure ulcers, impaired mobility, incontinence, Nutritional risk. | 04/28/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245258** | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED **02/27/2026** |
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| F0686<br>SS = D | Continued from page 22<br>resident at risk for worsening skin breakdown and infection.<br><br>Findings include:<br><br>R3's significant change in status assessment (SCSA) minimum data set (MDS) dated 2/6/26, identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side related to a cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition, a stage three pressure ulcer, and an unstageable deep tissue wound. R3 had functional limit in range of motion of the upper and lower body on one side and was dependent for toilet hygiene, lower body dressing, and transfers. R3 needed maximal assist with bed mobility. R3 was admitted to hospice on 1/30/26.<br><br>Review of R3's care plan revealed a focus statement for activities of daily living (ADL)s dated 2/20/26, which instructed staff to turn and reposition R3 every two hours and as needed. R3 preferred not to be woken at night. The care plan included a focus statement for limited mobility related to CVA dated 2/20/26, which instructed staff to report skin breakdown. However, the care plan didn't have a focus statement for being at risk for or having actual skin breakdown or interventions to monitor and assess the wounds.<br><br>Review of R3's electronic medical record (EMR) identified the following timeline:<br><br>9/15/25, admission to facility<br><br>9/18/25, a Skin and Wound Assessment identified no skin concerns.<br><br>From 9/19/25 to 11/7/25, R3's EMR didn't contain evidence of skin checks or assessments.<br><br>11/8/25, a Skin and Wound Assessment identified no skin concerns.<br><br>11/12/25, a Skin and Wound Assessment identified a new wound with no detail provided.<br><br>From 11/13 to 11/25/25, R3's EMR didn't contain evidence of skin checks or assessments.<br><br>11/14/25, a provider order for clotrimazole (a topical antifungal medication used to treat fungal infections) cream to right foot fourth and fifth digit three times per day for two weeks. Ensure you wash and dry area completely before applying clotrimazole. | F0686 | Continued from page 22<br><br>The Skin Integrity Policy was reviewed on 3/26/26 with no changes needed. All staff assigned re-educated immediately on repositioning techniques, reporting changes in skin condition, offloading, and timely documentation.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Random observational audits will be conducted to ensure repositioning schedules, Skin inspection documentation, Wound assessments and treatment orders are implemented as care planned. All licensed nurses and nursing assistants will receive education on: Pressure ulcer prevention, Proper repositioning techniques and frequency, Skin inspection, reporting skin concerns and documentation, Impact of nutrition and immobility on skin integrity, and importance of tissue tolerance studies. Any identified gaps were corrected immediately, including updating care plans and initiating interventions. Beginning the week of 4/13/26, Nurse Managers/designees will complete: Weekly audits x 4 weeks, then Monthly audits x 2 months until compliance is achieved. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0686<br>SS = D | Continued from page 23<br><br>11/26/25 at 5:39 a.m., a progress note: skin warm and dry, skin color within normal limits, and turgor is normal.<br><br>11/26/25 at 3 p.m., a provider order for skin charting one time a day every Wednesday using assessment, N Adv Skin Check.<br><br>11/26/25, a N Adv Skin Check identified a wound issue with no detail provided.<br><br>11/26/25 at 3:53 p.m., a progress note: resident has been refusing clotrimazole (a topical antifungal medication used to treat fungal infections) to right foot according to staff. During cares today, resident had redness, swelling, and foul smell. On-call provider updated and sent a request for oral antibiotics. Will await response.<br><br>11/26/25 at 5:23 p.m., a progress note: provider responded no oral antibiotic at this time. Provider to see him on next rounds and provided an order to soak foot and dry well once daily and will send a new order for spray clotrimazole to foot for seven days.<br><br>11/26/25, a provider order to soak right foot in warm soapy water daily. Ensure that foot is dried thoroughly before redressing. Apply clotrimazole aerosol spray between toes on both feet topically two times a day for infection.<br><br>11/27/25 3:03 a.m., a progress note: athlete’s foot to bilateral feet in between toes being treated with clotrimazole aerosol spray two times per day. Foot soaks with Epsom salts at bedtime prior to clotrimazole application.<br><br>11/27/25 at 9:41 p.m., a progress note: writer inspected resident's toe today and it appeared infected. It had an open area approximately three-quarters of a centimeter (cm) long by one cm wide. The area appeared red and had a yellowish pus coming out of it. Writer cleaned and dressed it per house standing orders. SBAR (a type of communication) placed in rounding book to update provider.<br><br>12/1/25, a provider visit summary identified resident complained of pain over the right fifth toe due to the ulcer.<br><br>12/1/25, a provider order for doxycycline 100 mg give one tablet two times a day for infection of the toe for 7 days until finished for 14 doses. | F0686 | | |

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| F0686<br>SS = D | Continued from page 24<br><br>12/2/25, a visit summary from Integrated Wound Care (IWC) identified R3 was evaluated and diagnosed with a stage three pressure ulcer of the right foot fifth interdigital space. The wound measured 1 centimeter (cm) by 1 centimeter, with heavy serous drainage, and a wound bed of 50% slough (dead or damaged tissue) and 50% granulation (new, healthy tissue).<br><br>From 11/28/25 to 12/9/25, R3's EMR didn't contain evidence of skin checks or wound assessments performed by facility.<br><br>12/10/25, EMR wound portal entry: new, in-house acquired stage three pressure ulcer at the right fourth interdigital toe space, full-thickness tissue loss measuring 1 cm by 1 cm.<br><br>12/16/26, N Adv Skin Check with issue noted, didn't provide detail and directed reader to see wound portal.<br><br>From 12/17/25 to 12/29/25, R3's EMR didn't contain evidence of skin checks or assessments by facility or by IWC.<br><br>12/29/25, a visit summary from IWC for toe wound.<br><br>1/5/26, a visit summary from IWC identified R3 was evaluated and diagnosed with a pressure ulcer of the right hip, unstageable, and measured two cm by two cm, with moderate serosanguineous drainage, and 100% slough tissue.<br><br>1/7/26, EMR wound portal entry: new, in-house acquired unstageable pressure ulcer on the right lateral hip measuring 1.93 cm by 2.32 cm.<br><br>1/12/26, a visit summary from IWC identified right hip wound was 100% slough and too painful to debride. IWC provided education regarding the need for repositioning.<br><br>1/12/26, EMR wound portal, a facility assessment for the hip and toe.<br><br>From 1/13 to 1/23/26, R3's EMR didn't contain evidence of a wound assessment.<br><br>1/13/26, provider orders for right foot fifth digit: every evening shift for wound, cleanse with wound cleanser. Apply stock antibiotic ointment, cut a piece of calcium alginate with silver to fit wound bed, cover with bordered gauze daily and as needed. | F0686 | | |

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| F0686<br>SS = D | Continued from page 25<br>1/14/26, provider orders for skin charting every evening shift on Tuesdays for shower day. Go to assessments and start form N ADV Skin Check.<br><br>1/23/26, EMR wound portal, a facility assessment for the hip and toe.<br><br>1/26/26 a visit summary from IWC identified sharp debridement was performed on the right hip to remove slough.<br><br>From 1/27 to 2/9/26, R3's EMR didn't contain evidence of a wound assessment.<br><br>2/6/26, a provider order for lying and sitting tissue tolerance to be discontinued when completed. Evidence of tissue tolerance testing wasn't located in R3's EMR.<br><br>2/9/26, IWC visit<br><br>2/17/26, a provider order for pressure injury right lateral hip, wash with normal saline, apply Vaseline and bordered foam, change daily and as needed.<br><br>2/17/26, a provider order for pressure injury right lateral hip, clean with wound cleanser, apply Vaseline and bordered foam, change daily and as needed.<br><br>During a continuous observation on 2/25/26 from 10:02 a.m. to 12:12 p.m., R3 was observed in the main dining room. At 10:02 a.m., R3 was asleep, leaning to the right in a Broda chair, with his right shoulder and knee lower than the left. There was a tray table in front and slightly to the right of R3, with three bowls and two cups with straws in them. At 10:42 a.m., RN-A straightened up R3's blankets and adjusted his baseball cap. At 10:48 a.m., the dietary manager (DM)-D came to his table and removed the bowls and left the cups. At 11:25 a.m., R3 has gotten a new tray of food placed on his table at his right side, he is using his left hand to feed himself. At 11:31 a.m., DM-D came by and straightened the table closer to his center and then arranged the bowls of food. At 11:45 a.m., NA in blue pants and green top came by and asked R3 if he was struggling and proceeded to hold the ice cream cup for him to take a couple bites. NA then walked away and set the ice cream cup on R3's tray on the opposite side he was eating from. At 12:12 p.m., nursing assistant (NA)-A wheels R3 from the dining room to his room. R3 was heard telling NA-A he wasn't ready to lay down yet, to which NA-A responded for him just to let her know when he was ready. R3 remained in the Broda chair leaning to his right, with his left foot off the footrest. | F0686 | | |

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| F0686 SS = D | Continued from page 26<br><br>During an interview on 2/25/26 at 2:02 p.m., NA-A stated R3 was in her group today and she thought he needed to be repositioned every two hours she knew he should've been repositioned sooner than this, but when she did bring R3 to his room, he didn't want to lay down but she said she should have repositioned him a little bit in his chair if he wanted to stay in the chair. NA-A stated it was important to reposition R3 so he didn't get any sores on his bottom, and he already had one on his side.<br><br>During an interview on 2/27/26 at 10:37 a.m., the acting director of nursing (DON) stated her expectation was for skin and wounds to be checked at a minimum of weekly with documentation about how a wound looked, its characteristics, dressing appearance, odor or signs of infection. For R3, hospice did wound care on their visits and documented in their own charting system. The DON explained R3 had wound rounds with a contracted wound nurse practitioner along with a facility nurse manager. The wound nurse documented the wound measurements. The DON stated the risk of not doing so would be something didn't get noticed or treated in time and could get worse. At 12:46 p.m., the DON stated her expectation would be for R3 to be repositioned every two hours.<br><br>During an interview on 2/27/26 at 11:18 a.m., primary care provider (PCP)-C stated he saw R3 on 12/1/25, and R3 had complained of pain in his toes on the right. The PCP stated he was concerned for infection in the toes and started doxycycline. The PCP would expect skin to be looked at every week, and stated the facility had a wound nurse who came to see the patients and she was very good, he was more comfortable with this.<br><br>A policy, Skin Integrity dated 5/21/25, identified its purpose was to provide guidance to nursing staff on identifying, evaluating, monitoring, and preventing resident skin integrity issues. The care center will assess each resident's risk for skin integrity issues at move in, quarterly, with any significant change in condition, and with a new or potential pressure ulcer and will identify interventions to help prevent skin integrity issues.<br><br>A licensed nurse will:<br><br>a. Assess the area and identify the cause, if possible. | F0686 | | |

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| F0686 SS = D | Continued from page 27<br><br>b. Remove any source of pressure or trauma to the area.<br><br>c. Clean the area and provide treatment per care center House Standing Orders.<br><br>d. Determine if the skin integrity issue is reportable to the State Agency (SA). If yes,<br><br>notify the Administrator and Director of Nursing and proceed with the SA reporting<br><br>process. (CCEP.MP.SNF.005 Maltreatment Investigation & Reporting)<br><br>e. Complete a Skin Incident report in the resident EHR.<br><br>f. Notify resident and/or responsible party.<br><br>g. Notify Provider and request treatment orders, if applicable.<br><br>h. Notify the Nurse Manager, Wound Nurse, or designee.<br><br>i. Initiate a new tissue tolerance for any newly opened area or redness.<br><br>j. Initiate appropriate preventive measures based on the immediate root cause.<br><br>C. Images of wound(s) will be taken utilizing approved equipment for medical<br><br>documentation, treatment planning, and monitoring progress.<br><br>Evaluation<br><br>A. Nurse Manager, Wound Nurse, or designee will assess and complete a root cause<br><br>analysis.<br><br>B. Interdisciplinary Team (IDT) will review the skin incident report and evaluation of root<br><br>cause for further recommendations.<br><br>C. The provider will review, to diagnosis, if root cause was not related to an injury (i.e., skin<br><br>tear, bruise), make recommendations, and/or initiate order(s). | F0686 | | |

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| F0686 SS = D | Continued from page 28<br><br>Monitoring<br><br>A. A licensed nurse will complete the skin check weekly and document it in the EHR.<br><br>B. Nurse Manager, Wound Nurse, or designee will assess all applicable wounds weekly<br><br>including pressure ulcers, venous ulcers, arterial ulcers, diabetic ulcers, MASD, and other<br><br>wounds of concern.<br><br>a. Documentation will be completed in the resident electronic health record and will<br><br>include describing the following characteristics:<br><br>i. Location<br><br>ii. Stage if pressure ulcer<br><br>iii. Measurements, including depth, undermining or tunneling/sinus tract.<br><br>iv. Exudate<br><br>v. Pain<br><br>vi. Wound bed<br><br>vii. Wound edges and surrounding tissue<br><br>viii. Signs and symptoms of infection<br><br>ix. Progress towards healing<br><br>x. Current interventions, including treatment, and any changes made to plan of<br><br>care.<br><br>b. The provider will be notified of any significant changes and/or a delay in healing. | F0686 | | |
| F0695 SS = D | Respiratory/Tracheostomy Care and Suctioning<br><br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br><br>The facility must ensure that a resident who needs | F0695 | F: 695 It is Franciscan Health Center's policy for residents to receive proper respiratory care.<br><br>The Director of Nursing will implement corrective action for resident R15 affected by this practice by: | 04/28/2026 |

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| F0695<br>SS = D | Continued from page 29<br>respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure the continuous positive airway pressure machine (CPAP) was properly cleaned and maintained for 1 of 1 resident (R15) reviewed for respiratory care.<br><br>Findings include:<br><br>R15's annual Minimum Data Set (MDS) dated 2/11/26, indicated R15 was cognitively intact. Section O: Special Treatments, Procedures, and Programs was not coded for CPAP.<br><br>R15’s face sheet dated 2/27/26, included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea.<br><br>R15's care plan revised 11/24/25, included CPAP settings but did not address standard cleaning and maintenance of CPAP for infection prevention.<br><br>R15’s provider orders dated 2/27/26, included:CPAP: staff to set up at HS and when in bed for naps. every shift Startup CPAP as machine is preprogrammed and will adjust to inhalation pressure needsNo evidence of orders for cleaning and maintenance of R15’s CPAP machine.R15’s treatment administration record (TAR) instructed staff to set-up the CPAP nightly and as needed for naps, but there were no instructions for cleaning and maintaining the CPAP. TARs dated 12/025, 1/2026, and 2/2026, had no instructions for cleaning and maintenance of R15’s CPAP machine.<br><br>During an observation on 2/23/26 at 12:33 p.m., R15’s CPAP machine had visible water in the chamber.<br><br>During an observation on 2/24/26 at 11:17 a.m., R15’s CPAP machine had visible water in the chamber.<br><br>During an observation on 2/25/26 at 1:24 p.m., R15’s CPAP machine had visible water in the chamber.<br><br>During an observation on 2/26/26 at 9:53 a.m., R15’s CPAP machine had a dry water chamber. | F0695 | Continued from page 29<br>R15’s CPAP machine was cleaned on 02/27/26.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents with CPAP are at risk of not having it properly cleaned and maintained.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>A facility-wide audit of all respiratory equipment, including CPAP/BiPAP machines, Nebulizers, Oxygen humidification equipment the audit ensured: Equipment is clean and properly maintained, no standing or contaminated water present, cleaning schedules are in place and followed, any identified concerns were corrected immediately following the manufactures guide.<br><br>All licensed nurses and nursing assistants were re-educated on: Proper cleaning and maintenance of CPAP and respiratory equipment, Infection control practices related to respiratory devices, Frequency of cleaning (daily, weekly, and as needed), Proper water usage and replacement, orders placed in TAR.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Random observational audits will be conducted starting the week of 4/13/26; Weekly audits x 4 weeks, then, Monthly audits x 2 months to ensure equipment is clean and properly maintained, No standing or contaminated water present.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0695<br>SS = D | Continued from page 30<br>During an interview on 2/26/26 at 2:30 p.m., nursing assistant (NA)-B and NA-C stated the nurses started the CPAP, monitored, and cleaned it.<br><br>During an interview on 2/26/26 at 2:44 p.m., registered nurse (RN)-A stated, nurses were responsible for placing the CPAP on the resident, monitoring it, and washing it per guidelines: daily empty and clean the humidifier and weekly clean the head gear, tubing, mask, and chin strap. RN-A stated CPAP orders, including cleaning, were on the TAR or MAR. They stated CPAP orders are expected on admission. They confirmed the importance of monitored use and cleaning for infection prevention.<br><br>During an interview on 2/26/26 at 2:57 p.m., acting director of nursing (DON) stated residents with CPAPs should have had orders in place for CPAP application, water chamber filling, and for cleaning the CPAP machine and tubing/mask. They stated they would be concerned if a resident didn't have CPAP orders because the orders on the TAR were what let nursing know they needed to perform these tasks.<br><br>During an observation on 2/27/26 at 11:30 a.m., R15's CPAP machine again had visible water in the chamber.<br><br>The facility provided undated document Cleaning Your CPAP/Bi-level Equipment instructed daily wiping of mask, daily washing and air drying of humidifier, and weekly washing of the mask and head gear.<br><br>A CPAP policy was requested but not received. | F0695 | | |
| F0725<br>SS = F | Sufficient Nursing Staff<br><br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35 Nursing Services.<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a) Sufficient Staff. | F0725 | F: 725 It is Franciscan Health Center's policy to have sufficient staff to provide for resident care in a timely manner.<br><br>The Director of Nursing will implement corrective action for residents R8 affected by this practice by:<br><br>Resident R8 will receive care in a timely manner.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents have the potential to be affected by this deficient practice. | 04/28/2026 |

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| F0725<br>SS = F | Continued from page 31<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>(i) Except when waived under paragraph (f) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review the facility failed to ensure they provided sufficient staffing per their facility assessment. In addition, the facility failed to provide sufficient staff to complete timely cares and assistance with checking and changing for 1 of 1 resident (R8) reviewed for activities of daily living and who were dependent on staff for assistance. This had the ability to affect all 36 residents residing in the facility.<br><br>Findings include:<br><br>The facility assessment, Franciscan Health Center Staffing Plan Staffing dated 10/23/25, identified the following staffing needs with an average daily census of 39:<br><br>Licensed nurses providing direct care, every day of the week for AM and PM shift there were two eight-hour positions, and the overnight (NOC) shift had one eight-hour position.<br><br>Unlicensed staff (NA), every day of the week for AM shift had five eight-hour positions, PM shift had four eight-hour positions, and NOC shift had two eight-hour shifts.<br><br>During the survey, the following staffing shortages were noted:<br><br>Monday 2/23/26, AM shift NA total was three from 6:30 a.m. until 12:30 p.m. when a fourth NA was added to the schedule. The resident census was 36. | F0725 | Continued from page 31<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>The facility conducted a review of staffing schedules, call-ins, replacement efforts, assignment sheets, and care delivery processes to identify patterns of staffing shortages that may have impacted on timely resident care. The facility assessment and staffing plan were reviewed against actual staffing levels and resident census to identify areas where staffing did not meet assessed needs.<br><br>The facility assessment and staffing plan were reviewed by administration and nursing leadership to ensure staffing levels align with resident acuity, census, care needs, and required services on all shifts, including weekends.<br><br>A staffing review process was implemented to monitor daily staffing levels against the facility assessment, with special attention to weekends, call-ins, and census fluctuations.<br><br>The scheduler, Director of Nursing, and Administrator were re-educated on the requirement to staff in accordance with the facility assessment and to promptly address staffing shortages.<br><br>A process was reinforced for escalating staffing concerns, including use of available management staff, on-call leadership, and agency or replacement staff when needed to maintain safe care delivery.<br><br>Assignment sheets and resident care groupings will be reviewed routinely to promote fair distribution of workload and to reduce the risk of missed or delayed cares.<br><br>Nursing staff were re-educated on reporting concerns related to inability to complete resident cares timely, including notifying the charge nurse or nursing leadership immediately when staffing levels interfere with care delivery.<br><br>Weekend staffing patterns and PBJ staffing variances will be reviewed routinely by administration and nursing leadership to identify trends and implement timely interventions.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including: | |

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| F0725<br>SS = F | Continued from page 32<br><br>Tuesday 2/24/26, AM scheduled for four NAs. The resident census was 36.<br><br>Wednesday 2/25/26, scheduled for three NAs. The resident census was 37.<br><br>Thursday 2/26/26, AM scheduled for four NAs, there was a call-in for AM shift so there was a fourth aid who stayed until 10 a.m., from 10 a.m. to 2:30 p.m., there were three NAs. The resident census was 38.<br><br>The PBJ Staffing Data Report for fiscal year 25, quarter 4 identified excessively low weekend staffing:<br><br>12/6/25, AM NA hours were actually 24, 32 were scheduled<br><br>12/7/25, AM NA hours were 16, 32 were scheduled. For PM, actual NA hours were 24 and 32 were scheduled.<br><br>12/8/25, PM NA hours were 24, 32 were scheduled<br><br>12/12/25, NOC NA hours were 16, 24 were scheduled<br><br>12/13/25, PM NA hours were 24 after 7 p.m., and 16 after 9 p.m., 40 were scheduled<br><br>12/14/25, AM NA hours 24, 32 were scheduled<br><br>12/15/25, PM NA hours were 24, 32 were scheduled<br><br>12/19/25, AM NA hours were 24, 32 were scheduled<br><br>12/20/25, PM NA hours were 24 after 9 p.m., and 16 after 9:30 p.m., 32 were scheduled<br><br>12/22/25, PM NA hours were 24 at 7 p.m., 32 were scheduled<br><br>12/27/25, PM NA hours were 16 at 10 p.m., 32 were scheduled<br><br>12/29/25, AM NA hours were 24, 32 were scheduled. PM NA hours were 24, 32 were scheduled<br><br>1/2/26, AM NA hours were actually 24, 32 were scheduled<br><br>1/4/26, NOC NA hours actually 8 after 4 a.m., 16 were scheduled<br><br>1/11/26, PM NA hours were actually 16 after 6 p.m., 32 were scheduled | F0725 | Continued from page 32<br><br>Audits will be completed Beginning the week of 4/13/26 the Director of Nursing or designee will audit staffing schedules, actual staffing worked, call-ins, replacement attempts, and care assignment sheets weekly for four weeks, then monthly for two months, to ensure staffing meets the facility assessment and resident care needs. In addition, audits will include review of timely completion of resident cares, including checking, changing, and ADL support. Any identified concerns will be addressed promptly through staffing adjustments, and follow-up review<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0725<br>SS = F | Continued from page 33<br>1/16/26, PM licensed nurses were actually 8 after 8 p.m., 16 were scheduled<br><br>2/6/26, PM NA hours were actually 24 and 32 were scheduled<br><br>2/9/26, PM NA hours were actually 24 and 32 were scheduled<br><br>2/16/26, AM NA hours were actually 32, 40 were scheduled<br><br>2/21/26, AM NA hours were actually 24, 32 were scheduled<br><br>2/22/26, AM NA hours were actually 24, 32 were scheduled<br><br>During the survey from 2/23/26 to 2/27/26, NA-E stated usually they have about 10 residents to care for during the day, but if they were short, it would be more. When they were short, NA-E described tactics like waiting to wash someone’s face or brushing their teeth until later in the day or having to do a bed bath instead of a tub bath or shower.<br><br>In an interview during the survey from 2/23/26 to 2/27/26, RN-E stated they were responsible for medications and treatments for 22 residents. RN-E also stated it was difficult to get it done; one medication pass ran into the next without time between. For example, today they were late with medications and treatments.<br><br>In an interview during the survey from 2/23/26 to 2/27/26, stated today after 10 a.m., NA-D had 12 or 13 residents in their group, and that was typical as they were consistently short-staffed. They added the nurse managers were helpful on the weekdays, but on the weekends, there weren’t any extra bodies here. NA-D stated they thought most of the important things got done, but they didn't get breaks. All core staff wrote a letter to management about 4 months ago and gave it to all of management and their union and they never heard anything back from anyone.<br><br>In an interview during the survey from 2/23/26 to 2/27/26, NA-F stated they were responsible for about 14 people. They felt like they could get their work done but didn’t have the extra time to do extras like visiting the residents or taking them outside anymore.<br><br>During an interview on 2/27/26 at 11:52 a.m., facility scheduler (FS)-F stated she put out a two-week schedule | F0725 | | |

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| F0725 SS = F | Continued from page 34<br>a month in advance every month, and there had been times she had to put out a schedule with holes in it despite attempts to fill them with facility casual staff or staffing agency staff. FS-F stated when there was a call-in the NOC nurse starts calling through to fill it and then she would take over when she got to work. The struggle is with call-ins with weekends. They have recently had a large number of call-ins for the weekend and there isn't the support staff here to help out. FS-F considers the nurse managers and MDS coordinator are as staff that is hands-on caregiving because they do help out when they are here and they are always willing to help.<br><br>During an interview on 2/27/26 at 12:14 p.m., the acting director of nursing (DON) confirmed there were times during the survey where they had call-ins they couldn’t replace. Staff didn’t really complain about the schedule, they might let the managers know and the managers would then help on the floor. The DON explained they have worked on making sure the care group sheets are fair and equal, have put out suggestion folders for staff to give feedback on the group sheets and shower schedule, and they just had a NA meeting the end of January so they talked about everyone's opinions and thoughts about where things are at currently. Nurse managers do help with things with med cart, help on the floor. There are days when a nurse calls in there are times when they may have to be just passing medications. The nurse managers are on call for the weekends, if there were an emergent staff issue, they would come in. An example would be if there were no RN in the building, or if they only had one or two aids.<br><br>Self-Care and Activities of Daily Living:<br><br>See also F677<br><br>R8:<br><br>R8’s quarterly Minimum Data Set (MDS) dated 1/7/26, identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, history of urinary tract infections, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living and was always incontinent of bowel and bladder.<br><br>A review of R8’s current order summary report included the following orders: | F0725 | | |

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| F0725 SS = F | Continued from page 35<br>One half vinegar one half water solution soak two times a day, soak right abdominal groin folds and under both breasts for 10 minutes with solution, pat dry, apply zinc cream, dated 2/26/26.<br><br>Skin charting one time a day every Saturday complete weekly per schedule, dated 11/22/25.<br><br>Myrbetriq (medication used to treat overactive bladder) oral tablet extended release 24 hour 60 milligrams (mg) one time a day related to stress incontinence, dated 10/11/25.<br><br>R8's history order summary report included the following orders:<br><br>Nystatin external powder 100000 unit per gram (GM) apply to affected areas tropically as needed for two times a day apply to abdominal folds, groin, under breasts, dated 10/10/25.<br><br>Monitor and document signs and symptoms of urinary tract infection and vitals every shift, document in progress notes, started on 1/26/25.<br><br>R8's care plan dated 10/10/25, identified R8 had an activity of daily living deficit related to activity intolerance, impaired balance. Interventions included a toileting schedule every two to three hours and per their request. The care plan identified "frequently incontinent of bowel and bladder". In addition, bowel incontinence related to immobility. Interventions included to check every two hours and assist with toileting as needed.<br><br>R8's care plan dated 10/10/25, identified R8 was at risk for insomnia. Interventions included to maintain a consistent schedule with daily routine.<br><br>R8's care plan dated 1/7/26, identified R8's personal care preferences. Interventions included, "I prefer to be woken around and be out of bed after 9:00 a.m.. Do not wake me up before 9:00 a.m.."<br><br>A review of R8's weekly skin assessments revealed the following:<br><br>2/21/26, moisture documented as "normal", noted "No, there are no skin concerns."<br><br>1/24/26, (about a month earlier) moisture documented as "normal", noted "No, there are no skin concerns."<br><br>1/21/26, moisture documented as "normal", noted "No, | F0725 | | |

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| F0725 SS = F | Continued from page 36 | F0725 | | |

there are no skin concerns.”

1/6/26, (about two weeks earlier) documented as “other” quarterly MDS.

Skin group page 18 documented as “No skin issues” further pages identified perineum, right breast, left breast, “rash” all documented as resolved.

12/10/25, (about 4 weeks earlier) moisture documented as “normal”, noted “No, there are no skin concerns.”

12/2/25, moisture documented as “normal”, noted “No, there are no skin concerns.”

11/29/25, moisture documented as “normal”, noted “No, there are no skin concerns.”

10/14/25, (about 6 weeks earlier) moisture documented as “normal”

10/10/25, admission skin assessment, left and right breast, perineum rash, present on admission, chronic greater than 3 months.

A review of R8’s progress notes revealed the following:

2/24/26, 3:32 p.m., “Writer asked to assess resident skin under breasts and abd (abdominal)/groin folds. Skin condition not improving with current treatment of Nystatin powder. Writer called Dr. XXXXX and received new order as follows: Soak right abdominal/groin folds and under both breasts for 10 minutes with 1/2 vinegar 1/2 water solution. Pat dry. Apply Zinc cream. Twice daily. Writer also discussed adding resident to list for wound care NP to see.”

2/10/26, 10:47 a.m., New orders from MD “Please keep pt (patient) dry r/t (related to) recurrent UTIs (urinary tract infections).”

A continuous observation started on 2/25/26 at 7:05 a.m. and ended at 11:01 a.m., four hours. At the beginning of the observation R8’s door was closed and the lights in the hallway were dim. No staff were observed going into R8’s room during the four-hour window.

On 2/25/26 at 11:01 a.m., nursing assistant (NA)-B knocked and entered R8’s room. R8 gave permission to observe cares. NA-B left the room to get the nurse for “some skin issues”.

-at 11:15 a.m., registered nurse (RN)-E entered the

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| F0725 SS = F | Continued from page 37<br>room, performed hand hygiene, put on gloves and opened R8's brief. R8's skin was bright red in groin area (both sides), extending across her abdomen under pannus (hanging, apron-like layer of skin and fat that sags over the lower abdomen and pubic region). The bright red skin extended from one to four inches in groin and pannus areas. Under R8's breasts the skin was bright red with the redness extending two to three inches under breasts. RN-E told R8 the treatment with nystatin was not working and her provider changed the treatment order, RN-E told her it was a vinegar and water mixture and "it might sting".<br><br>-at 11:28 a.m., R8 was rolled to her left side, the brief was soaked yellow from urine and R8 had a moderate amount of formed brown stool, in her brief and stuck to her skin. R8's skin was intact on her buttocks. A new brief was positioned under R8.<br><br>-at 11:35 a.m., RN-E returned to finish the treatment process. She removed the 4x4's, dried R8's skin, and put on the new skin treatment, she told R8 what she was doing and asked her if it was hurting. R8 periodically would answer yes or wince.<br><br>-at 11:43 NA-B asked R8 if she had wanted to be woken up earlier, R8 responded with "yes, wake me up".<br><br>During an interview on 2/23/26 at 1:41 p.m., R8 stated she sometimes had to wait two hours to get the call light answered. R8 stated one night she was left "wet" all night until the next morning.<br><br>During an interview on 2/24/26 at 10:25 a.m., R8 was dressed for the day and seated in her wheelchair in her room. R8 stated she liked to get up about 9:00 a.m."<br><br>During an interview on 2/25/26 at 11:00 a.m., nursing assistant (NA)-B stated R8 had last been checked and changed at 6:30 a.m., by the night shift. NA-B stated she was aware R8 liked to be up around 9:00 a.m. and stated it had been too long to go without checking for incontinence. NA-B stated they were "down" one nursing assistant and were sometimes short. NA-B stated they were taking care of 14 residents by themselves.<br><br>During an interview on 2/26/26 at 1:18 p.m., RN-A reviewed R8's care plan and stated R8's preference was to be up after 9:00 a.m..RN-A verified four hours was too long to go without checking for incontinence and changing a resident's brief. RN-A stated R8 was having moisture related skin concerns, said it might be related to incontinence. RN-A reviewed the note from the provider to keep resident dry related to recurrent | F0725 | | |

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| F0725<br>SS = F | Continued from page 38<br>urinary tract infections. RN-A stated they had been treating the redness in her groin and under her breasts since October 2025.<br><br>During an interview on 2/27/26 at 9:40 a.m., RN-A reviewed R8's skin assessments and verified they were being documented as moisture “normal” and “no skin concerns”. RN-A verified there were gaps sometimes as long as month with no skin assessment documented as completed. RN-A stated the expectation was skin checks would be completed weekly to monitor skin and keep track of any skin problems.<br><br>During an interview on 2/27/26 at 10:59 a.m., the acting director of nursing (acting DON) stated it was the expectation the skin checks would be completed weekly on the shower day. The acting DON stated if the resident refused their shower, it was still the expectation the skin checks would be completed. If the resident refused the skin checks the acting DON stated, the expectation would be for the nurse to re-approach and notify the nurse manager of the refusal. The acting DON stated the weekly skin checks were important to look for skin breakdown. The acting DON stated checking and changing was also important to complete as identified in the care plan, again stated the purpose was to prevent skin breakdown.<br><br>During an interview on 2/27/26 at 1:47 p.m. licensed practical nurse (LPN)-B stated they had finished R8's treatment and noted skin under breasts was “pink”, in the groin area “bright red”. LPN-B stated R8's skin looked improved from the previous week. LPN-B stated R8 said it burned a little during the treatment.<br><br>Skin Integrity dated 5/21/25, identified “nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice.” In addition, the policy identified skin checks would be completed weekly by a licensed nurse and the provider would be notified of any significant changes or a delay in healing. The policy further identified skin issues would be tracked, trended and reported at the Quality Assurance Performance Improvement meetings to determine if corrective action needed to be taken. | F0725 | | |
| F0761<br>SS = E | Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>Drugs and biologicals used in the facility must be | F0761 | F: 761 It is Franciscan Health Center's policy to ensure medications and supplies are available for use that are not expired.<br><br>The Director of Nursing will implement corrective action for resident R15 affected by this practice by: | 04/28/2026 |

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| (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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| F0761<br>SS = E | Continued from page 39<br>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to ensure the proper labeling of medications and the removal of expired medications and supplies occurred in one of one medication rooms and one of two medication carts. In addition, the facility failed to ensure the proper storage of resident medications for 1 of 1 resident (R15) that self-administer medications. These deficient practices had the potential to impact all residents who received supplies and medications from reviewed medication rooms and carts.<br><br>Findings include:<br><br>During a review of Medication cart A on 2/24/26 at 3:20 p.m., with registered nurse (RN)-C. RN-C confirmed the following findings: Drawer one contained an undated insulin glargine pen for resident (R1). RN-C stated medications like insulin need to be dated when removed from the refrigerator because the expiration date of the medication changed when it moved to room air and most insulins expired after 30 days. RN-C stated R1's insulin pen was unused, but they were unsure when it was removed from the refrigerator because it was not dated. RN-C returned R1's undated insulin pen to the medication cart. Four inhalers in drawer one were reviewed. RN-C confirmed three inhalers were in use but | F0761 | Continued from page 39<br><br>The medication room was cleaned out, and all expired products were discarded.<br><br>All expired medications and supplies identified (including IV E-kit contents) were immediately removed and properly disposed of per facility policy. All undated insulin pens were immediately removed and discarded. New insulin pens were issued, labeled with date opened, and staff were re-educated on insulin labeling requirements, including expiration guidelines available at each medication cart.<br>requirements, including expiration guidelines available at each medication cart.<br><br>A new Self-Administration of Medication (SAM) assessment was completed. It was determined that the resident requires assistance with medication storage and handling.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>Medications secured appropriately per policy, Staff assistance provided for medication access and administration The Director of Nursing (DON), Nurse Managers, and/or designee completed: An audit of all medication rooms, carts, and emergency kits to ensure: No expired medications or supplies are present. All medications are properly labeled (including insulin open dates), An audit of all residents approved for self-administration to ensure SAM assessments are current, Medications are stored safely and securely, Resident abilities match level of independence allowed, and any discrepancies identified were immediately corrected .<br><br>Weekly medication room and cart audit tool (including expiration checks and labeling compliance), IV kit was discontinued. IV supplies will be ordered PRN. With quarterly reviews of SAM to monitor assessment | |

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<tr><th>(X4) ID PREFIX TAG</th><th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th><th>ID PREFIX TAG</th><th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th><th>(X5) COMPLETION DATE</th></tr>
<tr><td>F0761<br>SS = E</td><td>Continued from page 40<br>had not been dated when opened and indicated inhalers should be dated when opened.<br><br>During a review of the medication room on 2/26/26 at 12:12 p.m., with RN-A. RN-A confirmed the following findings: Lower cabinet one, below the sink, contained four boxes of Nestle arginine powder (nutritional protein supplement for human consumption), personal unlabeled electric shavers, four bottles of Clippercide, and cleaning supplies including bleach. RN-A confirmed 3 boxes of the arginine powder expired on 12/15/25 and stated they needed to dispose of the boxes. RN-A indicated they were not sure what the guideline was for storing food products and chemical products together. Lower cabinet two moving left to right contained an intravenous emergency kit (IV E-kit) labeled first drug expired 8/31/23. The IV E-kit included a normal saline IV bag which expired 9/20/23, a dextrose with half normal saline IV bag which expired 8/2023, three heparin syringes which expired 11/30/23, and a Continu-Flo solution set with regulator which expired 7/4/25. RN-A confirmed the expired items in the kit and stated the items needed to be discarded.<br><br>During an observation and interview on 2/26/26 at 10:02 a.m., licensed practical nurse (LPN)-A unlocked and opened medication cart A and removed R1's insulin glargine pen. LPN-A confirmed R1's insulin pen was undated and indicated that the pen had been partially used. LPN-A removed the insulin pen from the drawer and stated they would get a new pen since they do not know when it was opened.<br><br>During an interview on 2/26/26 at 1:38 p.m., the acting director of nursing (DON) stated insulin pens should be dated when removed from the refrigerator and if a nurse found a pen that was not dated, they expected the nurse would review the policy and do a calculation for administration. Dating the insulin pen was important because insulin was only good for so long. They stated they did not believe the Nestle Arginine drink mix was normally stored under the sink in the medication room and confirmed concerns about cleaning chemicals and consumables being stored together under the sink. The acting DON stated the facility checked for expired medication and supplies weekly on the night shift. They did not feel staff would use expired supplies but indicated the expired iv kit items and protein supplements would need to be disposed of.<br><br>A facility conducted inventory of their intravenous emergency kit (IV E-kit) on 2/26/26 found the following items were expired: 4 normal saline (NS) 1-liter (L) intravenous (IV) bags expired 9/2023, 2 half NS L IV</td><td>F0761</td><td>Continued from page 40<br>completion and compliance, Nurse Managers will conduct routine spot checks.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Medication storage and labelling: Random audits will be conducted No expired medications/supplies present, Proper labeling (including insulin dating), Compliance with storage requirements, no expired medications/supplies present beginning the week of 4/13/26, 3x/week x 2 weeks, 2x/week x 2 weeks, 1x/week x 1 week, until compliance is achieved.<br><br>SAM administration audits: Weekly audits x 4 weeks, then, Monthly audits x 2 months to ensure: SAM assessments are current, Medications are stored safely, Care plans reflect resident abilities.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026</td><td></td></tr>
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| F0761<br>SS = E | Continued from page 41<br>bags expired 8/2023, 2 dextrose with half NS L IV bags expired 8/2023, 2 dextrose with half NS and potassium IV bags expired 9/2023, 2 dextrose L IV bags expired 9/2023, 3 heparin pre-filled syringes expired 11/2023, 3 IV start kits expired 5/2024, 3 central line dressing change kits expired 1/2024, 4 22-gauge IV catheters expired 10/1/23, 4 24-gauge IV catheters expired 2/2024, and 3 adapter caps expired 9/2025.<br><br>The facility provided manufacturer document Insulin Glargine – Insulin Glargine Injection Solution dated 3/3/25, the section Instructions for Use directed pens should be thrown away after 28 days if they are stored at room temperature.<br><br>The facility provided Thrifty White Pharmacy Services document Insulin Administration – Pen dated 1/2018, directed to document the date open on the pen when it was obtained from the refrigerator.<br><br>The facility policy Medication, Treatment, and Medical Supplies Storage dated 7/27/16, directed nursing staff to check expiration date prior to utilizing medications, treatment supplies, or medical supplies, and to conduct weekly audits of the medication storage room and medication carts for expired medications, treatment supplies, or medical supplies. Any found to be expired will be disposed of or destroyed, depending on the type of medication, treatment supply, or medical supply.<br><br>A facility policy on insulin administration and insulin pens was requested but not received.<br><br>R15:<br><br>R15's annual Minimum Data Set (MDS) dated 2/11/26, indicated R15 was cognitively intact.<br><br>R15's facesheet dated 2/27/26, included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea.<br><br>R15's care plan last revised 11/24/25, in special instructions, identified self-administration of medication (SAM) of nebulizer treatments after set-up.<br><br>R15 current provider orders dated 2/27/26, included:Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 3 ml inhale orally every 4 hours as needed for SOB- Spasm of Lung Air Passages Ok to self-administer after set upBudesonide Inhalation Suspension 0.5 MG/2ML | F0761 | | |

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| F0761<br>SS = E | Continued from page 42<br>(Budesonlde (Inhalation)) 2 ml inhale orally two times a day for Chronic Obstructive Lung Disease Rinse mouth after each use May self-administer after set upIpratroplum-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratroplum-Albuterol) 3 ml inhale orally four times a day for Chronic Obstructive Lung Disease May self-administer after set upNo evidence of orders for Magnesium Citrate 200 mg, Pure ZZZs Melatonin, or Centrum Men's Multivitamin.R15's medication administration record (MAR) dated 2/27/26, instructed that R15 may self-administer the following medications after set-up by the nurse:Budesonide Inhalation Suspension 2 ml inhaled orally two times a day.Albuterol Sulfate Inhalation Nebulization Solution 3 ml inhaled orally every 4 hours as needed.Ipratropium-Albuterol Inhalation Solution 3 ml inhaled orally four times a day.R15's SAM assessment dated 2/11/26, reported R15 was approved for self-administration of medications, including inhalants and oral medications, and was safe to leave medications at bedside after set-up, but was not capable of storing medications in a secure location and required assistance opening and closing medication containers.<br><br>During an observation on 2/23/26 at 12:33 p.m., R15 was sitting in a wheelchair in their room completing a nebulizer treatment. There were three supplement bottles in a basket to the right of R15's recliner. Three unopened nebulizer ampules were on the bedside table in front of them. R15 stated they did their own nebulizer treatments.<br><br>During an observation on 2/24/26 at 11:17 a.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner.<br><br>During an observation on 2/25/26 at 1:24 p.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner.<br><br>During an observation on 2/26/26 at 9:53 a.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner. R15 stated they no longer take these vitamins.<br><br>During an interview on 2/25/26 at 1:55 p.m., RN-B stated medications and nebulizers can be kept at bedside if it is ordered. They stated R15 could | F0761 | | |

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| F0761<br>SS = E | Continued from page 43<br>self-administer nebulizer treatments after set-up by nurses.<br><br>During an interview on 2/25/26 at 2:05 p.m., acting DON stated with SAM orders directing staff to set-up nebulizer treatments, staff would fill the nebulizer medication cup and return after treatment was completed to clean it. They stated for a resident to have medications at bedside, a SAM assessment needed to be completed. R15 had a SAM assessment previously which allowed them to set up their own nebulizer and have a small supply at bedside.<br><br>During an interview on 2/26/26 at 2:44 p.m., RN-A stated for a resident to have medications in their room, a SAM assessment needed to be completed. They confirmed the importance of making sure the medications are secured so someone else cannot get them.<br><br>During an interview on 2/26/26 at 2:57 p.m., the acting DON stated when a resident brought medications, nurses secured them until a SAM assessment was completed. They confirmed medications in a resident room required orders and needed to be secured. The acting DON stated they would not want vitamin bottles stored in R15's room and they were concerned that other residents could get an unsecured medication.<br><br>During an interview on 2/26/26 at 4:22 p.m., the acting DON confirmed three bottles of gummy vitamins were in R15's room and R15 was not taking them. An inventory was completed with acting DON on the vitamins they removed from R15's room: Magnesium Citrate 200 mg gummies which expired 2/2025, Pure ZZZs Melatonin gummies which expired 6/2025, and Centrum Men's Multivitamin gummies which expired 7/2024.<br><br>The facility policy Self-Administration of Medication by Residents dated 2/27/24, directed nursing staff to conduct a SAM assessment if a resident wanted to take their own medication. This assessment determined which medications were appropriate to self-administer, where to store the medications, and what assistance the resident needed to actively participate in the administration of their medications. | F0761 | | |
| F0812<br>SS = E | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must - | F0812 | F: 812 It is Franciscan Health Center's policy to store, prepare, distribute, and serve food in accordance with professional standards of food service safety.<br><br>The Dietary Manager will implement corrective action for residents affected by this practice by: | 04/28/2026 |

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| F0812<br>SS = E | Continued from page 44<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to ensure food safety practices were followed during meal preparation. This had the potential to affect all residents who ate food prepared in the kitchen.<br><br>Findings include:<br><br>On 2/23/26 at 12:00 p.m., raw chicken was observed in a covered plastic container resting in a sink. Dietary Manager (DM)-D stated the chicken was brining in a solution with lemon and garlic.<br><br>On 2/23/26 at 12:04 p.m., Cook C-A stated the chicken had been thawed in the refrigerator and stated the solution was salt, sugar, thyme, lemons, and water. C-A stated it had been brining for about 30 minutes outside of the refrigerator and would be placed on pans and baked in about 10 minutes.<br><br>On 2/23/26 at 12:09 p.m., C-A checked the temperature of the brine it was 36.5 degrees Fahrenheit. A chicken breast was checked and the temperature was 32.9 degrees Fahrenheit. C-A stated it would have been better to brine the chicken in the cooler or the refrigerator.<br><br>A review of the recipe for Lemon-Thyme Brined Chicken from Dining Manager dated 2026, identified the following, “Add the chicken to a resealable plastic bag or container with lid; then add in the liquid. Seal the | F0812 | Continued from page 44<br><br>No individual residents were specifically cited.<br><br>The Dietary Manager will assess residents having the potential to be affected by this practice including:<br><br>All residents have potential to be affected by deficient practice.<br><br>The Dietary Manager will implement measures to ensure that this practice does not recur including:<br><br>All potentially affected food items were inspected and were within temperature range. Food temperatures meet safety standards when cooked, prior to being served.<br><br>Brining poultry protocol will be: prepare brine. If heated, it will be cooled down to below 40 degrees before combining poultry. Poultry will be placed in container or large bags and brine added. The container or bag will be placed in cooler for stated amount of time per recipe instructions.<br><br>Food Storage and Temperature policy was reviewed, and all dietary staff will be trained on policy.<br><br>The Dietary Manager will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Random audits food preparation and food storage will be completed by Dietary Manager/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of 04/13/2026.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation. | |

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| F0812 SS = E | Continued from page 45<br>bag and refrigerate for 4 hours (no more than 8hours).”<br><br>Perishable Food Management dated 8/29/22, identified the following, “All perishable food will be appropriately managed (cooked, cooled and stored) to prevent bacteria from multiplying or forming toxins.” In addition, the policy identified the following, “Examples of foods that must be kept refrigerated for safety include meat, poultry, fish, dairy products, and all cooked leftovers.” | F0812 | | |
| F0880 SS = E | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be | F0880 | F: 880 It is Franciscan Health Center’s policy to use PPE properly when caring for residents with infections.<br><br>The Director of Nursing will implement corrective action for residents R3 and R6 affected by this practice by:<br><br>Staff caring for R3 and R6 will use PPE properly while providing care.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents on transmission-based precautions have the potential to be affected by this deficient practice.<br><br>The Director of Nursing (DON), Infection Preventionist, or designee completed a house-wide audit to ensure: Appropriate EBP implementation, Proper signage and PPE availability; Care plans and orders reflect current infection control needs.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>Enhanced Barrier precaution Integrity Policy was reviewed on 3/26/26 with no changes needed.<br><br>All licensed nurses and nursing assistants received mandatory re-education on: Enhanced Barrier Precautions (EBP), Hand hygiene, PPE use during high-contact care, Cleaning and disinfection of shared equipment. .<br><br>The Director of Nursing will monitor corrective actions | 04/28/2026 |

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| F0880<br>SS = E | Continued from page 46<br>followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP) were in place for a resident who had chronic pressure ulcers (PU)s requiring ongoing wound care. This failure had the potential to increase the risk of transmission of multidrug-resistant organisms (MDROs) during high contact resident care activities for 1 of 1 resident (R3) reviewed for wound care. In addition, the facility failed to ensure appropriate infection control was completed during personal cares for 1 of 1 resident (R6) whose cares were observed. The facility also failed to provide appropriate hand hygiene, properly follow EBP precautions, and complete cleaning of shared equipment. | F0880 | Continued from page 46<br>to ensure the effectiveness of these actions including:<br><br>The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits weekly audits x 4 weeks, then monthly audits x 2 months beginning the week of 4/13/26 for: EBP compliance, Hand hygiene adherence, PPE use, equipment cleaning practices .<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0880<br>SS = E | Continued from page 47<br><br>Findings include:<br><br>According to the Centers for Disease Control (CDC)'s web page, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, residents with wounds (including chronic wounds such as pressure injuries, diabetic foot ulcers, and venous stasis ulcers) are considered at increased risk for MDRO transmission and should be cared for using EBP during high-contact care activities. The CDC doesn't define chronic wounds by duration, but rather by presence and need for on-going wound care.<br><br>R3's significant change in status assessment (SCSA) minimum data set (MDS) dated 2/6/26, identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), and severe protein-calorie malnutrition. The MDS identified R3 was at risk for and had actual pressure ulcers including a stage three and an unstageable deep tissue injury. R3 had a functional limit in range of motion of the upper and lower body on one side and was dependent with toilet hygiene, lower body dressing, transfers, and needed maximum assistance with bed mobility.<br><br>R3's medication administration record (MAR) for the month of February 2026, identified wound care was provided daily to R3's foot and hip.<br><br>R3's provider orders dated 2/27/26 didn't identify an order for EBP.<br><br>R3's care plan contained an undated banner message on the first page titled "Special Instructions" which contained in part the following information, "EBP related to wound", with no further details or instructions. The care plan didn't contain a focus statement for impaired skin integrity or wounds.<br><br>A document, Integrated Wound Care (IWC) dated 12/3/25, identified R3 was evaluated and diagnosed with a stage three pressure ulcer of the right foot fifth interdigital space. The wound measured one centimeter (cm) by one centimeter, with heavy serous drainage, and a wound bed of 50% slough (dead or damaged tissue) and 50% granulation (new, healthy tissue). A second IWC document dated 1/5/26, identified R3 was evaluated and diagnosed with an unstageable deep tissue injury to the right lateral hip measuring two cm by two cm, with moderate serosanguineous drainage, and 100% slough tissue. | F0880 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F0880 SS = E | Continued from page 48<br>During an observation on 2/26/26 at 10:47 a.m., registered nurse case manager (RNCM) with hospice and nursing assistant (NA)-D provided wound care to R3 without donning gowns. There wasn’t a personal protective equipment (PPE) station in the room, nor was there a sign on R3’s door indicating EBP was in place.<br><br>During an interview on 2/26/26 at 1:32 p.m., the acting director of nursing (DON) stated they would use EBP for a chronic wound, and a chronic would be something present three months or longer or are not healable or resolved. They have discussed R3 and EBP, but they decided they weren't to that threshold yet.<br><br>A policy, Enhanced Barrier Precautions dated 8/20/24, identified its purpose was to provide guidelines to staff in the application of EBP to safely care for residents colonized or infected with MDROs. EBPs shall be used when providing high contact care to residents who are colonized or are infected with an MDRO when contact or other precautions do not apply. EBP should also be used for residents with chronic wounds and/or indwelling medical devices (e.g., urinary catheters, feeding tubes, central line, tracheostomy). Chronic wounds are defined as pressure ulcer, diabetic foot ulcer, unhealed surgical wound, and venous stasis ulcer. Skin breaks or skin tears are not considered a chronic wound. High-contact resident care activities included wound care, dressing, bathing, showering, changing linen, hygiene care, toileting care.<br><br>R6:<br><br>Review of R6's quarterly MDS dated 1/21/26, identified R6 as moderately cognitively impaired.<br><br>R6’s facesheet included diagnoses of stage 4 pressure ulcer (PU4) left buttock, congestive heart failure (CHF), and venous insufficiency.<br><br>R6's care plan revised 11/24/25, instructed:<br><br>R6 required assistance of two when repositioned and when transferred with full sling mechanical lift<br><br>use Enhanced Barrier Precautions (EBP)<br><br>monitor dressing to ensure it is intact and adhering and report lose dressing to treatment nurse<br><br>provide skin care per facility guidelines<br><br>wound care per treatment order of specialized | F0880 | | |

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| F0880<br>SS = E | Continued from page 49<br>practitioner for wound management<br><br>R6's provider orders dated 2/27/26 included:<br><br>PU (pressure ulcer) to left buttock: as needed for If dressing soiled, came off during cares/shower etc Staff to use foot cradle in bed. Encourage Frequent offloading Q 2hrs (every 2 hours) and up in chair daily for 2 hrs.<br><br>PU to left buttock: every evening shift related to pressure ulcer of left buttock, stage 4 WC (wound care) to wound bed, ¼ strength Dakins packing (apply kerlex gauze and pack wound), cover with bordered foam to secure daily and prn (as needed), Encourage frequent offloading every 2 hours and up to chair daily for 2 hours.<br><br>Pressure Ulcer L-heel every day shift every other day Wound cleaner, collagen sprinkles to wound bed, apply barrier swab to peri wound, and border foam to cover QOD (every other day) and PRN (as needed). Off load pressure.<br><br>Pressure Ulcer L-heel as needed for as needed Wound cleaner, collagen sprinkles to wound bed, apply barrier swab to peri wound, and border foam to cover QOD (every other day) and PRN (as needed). Off load pressure.<br><br>R6's Integrated Wound Care (IWC) progress notes dated 2/23/26 identified pressure wounds to left buttock, left heel, and right ankle. It also identified frequent incontinence of bowel and bladder results in difficulty with healing.<br><br>R6's treatment administration record (TAR) dated 2/27/26, instructed staff to:<br><br>provide wound care to left buttock PU4 every evening shift, packing the wound and covering with bordered foam to secure daily and as needed if soiled or change off in shower etc.<br><br>monitor left buttock PU4 daily and create a progress note<br><br>provide wound care to left heel PU every day shift every other day and as needed | F0880 | | |

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| F0880<br>SS = E | Continued from page 50<br><br>During an observation on 2/25/26 at 12:49 p.m., NA-A entered R6's room. R6's door had an EBP sign on the door. NA-A wearing gloves, but no gown, straightened R6's bedding and adjusted a lift sling around R6 as they sat in their wheelchair. Registered nurse (RN)-B with gloves but no gown arrived to assist NA-A with using a mechanical full sling lift to transfer R6 from wheelchair to bed. NA-A and RN-B put on gowns and changed R6's brief. NA-A removed PPE, (did not sanitize hands), adjusted blankets, elevated R6's ankles, moved bedside table, opened blinds, and exited R6's room without hand sanitizing. NA-A left mechanical lift outside R6's door and took the trash to dirty utility room. They unlocked dirty utility room, disposed of trash, and washed hands. NA-A did not return to sanitize the mechanical lift.<br><br>During an interview on 2/25/26 at 2:28 p.m., NA-A confirmed they had not gowned for transferring R6 from wheelchair to bed, had not hand sanitized after removing gloves before touching R6's personal items, had not sanitized before exiting R6's room, and had not sanitized the mechanical lift after use. They confirmed the EBP sign on R6's door. They stated they should have done these steps for proper infection control.<br><br>During an observation on 2/26/26 at 9:02 a.m., licensed practical nurse (LPN)-A was in R6's room, in gown and gloves, changing right ankle dressing and left heel dressing. They had completed the right ankle dressing change, changed gloves without hand sanitizing, removed left heel dressing and cleansed the wound, changed gloves without hand sanitizing, put wound cleanse spray in bin, and applied clean dressing to left heel. LPN-A removed PPE, hand sanitized, and left R6's room. LPN-A returned to R6's room with NA-A, both gloved but did not gown, and repositioned R6.<br><br>During an interview on 2/26/26 at 10:02 a.m., LPN-A confirmed they should have sanitized hands with glove changes during dressing change. They stated hand sanitizing is important for infection control especially between removing the soiled dressing and applying a new dressing. They also confirmed R6 was on EBP and stated the sign on R6's door indicated gowning for transfers and dressing changes, but they were unsure about repositioning.<br><br>During an interview on 2/26/26 at 2:57 p.m., acting DON stated they expected staff to perform proper hand sanitizing between residents, after cares, when moving from dirty dressing to clean dressing, and when hands were visibly soiled. They stated it was important to | F0880 | | |

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| F0880<br>SS = E | Continued from page 51<br>protect residents from further infection with EBP, and they expected staff to follow EBP door signs. Staff should wear PPE for transfers, position changes, and close cares. They also expected staff to sanitize shared equipment after each use.<br><br>A facility provided Enhanced Barrier Protection sign, received 2/26/26, instructed staff to wear gloves and a gown for high-contact resident care activities, including dressing, transferring, changing briefs, and wound care.<br><br>A facility policy Enhanced Barrier Protection dated 8/20/24, instructed staff to use EBP for high-contact cares including when briefs were changed, when wound care was performed, and when residents were dressed, bathed, and transferred.<br><br>A facility policy Hand Hygiene revised 1/21/25, instructed staff to perform handwashing or hand sanitizing before and after direct contact with a resident, when moving from a contaminated body site to a clean body site during resident care, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and after removing gloves or gowns.<br><br>A facility policy Cleaning Disinfecting Resident Care Equipment revised 1/25/22, instructed staff to disinfect mechanical lifts after each use. Staff were to use a disinfectant wipe to clean areas that came in contact with the resident and use a second disinfectant wipe to disinfect these areas. | F0880 | | |
| F0883<br>SS = D | Influenza and Pneumococcal Immunizations<br><br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br><br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; | F0883 | F: 883 It is Franciscan Health Center's policy to keep residents' immunization records up to date.<br><br>The Director of Nursing will implement corrective action for residents R8, R12, and R13 affected by this practice by:<br><br>R8: The immunization record was corrected in the EHR to reflect that VIS was provided and consent was obtained on 9/17/25 and pneumococcal vaccination administered. Vaccine administration dated 1/22/26.<br><br>R12: The immunization record was corrected in the EHR to reflect that VIS was provided and consent was obtained on 9/17/25 and vaccination administered. Influenza vaccine administration dated 11/4/25 was verified. | 04/28/2026 |

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| F0883<br>SS = D | Continued from page 52<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br><br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br><br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review the facility failed to offer influenza and pneumococcal vaccinations and or provide education according to Centers for Disease Control (CDC) guidelines for 3 of 5 residents (R12, R13, R8) reviewed for vaccinations. | F0883 | Continued from page 52<br>R13: The immunization record was corrected in the EHR to reflect that VIS was provided and consent was obtained on 9/17/25 and vaccination administered. Influenza vaccine administration dated 11/4/25 was verified.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents have the potential to be affected by this deficient practice.<br><br>All current residents’ immunization status will be evaluated to identify any deficiencies noted.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>IDT reviewed the Resident Immunization Policy and processes related to resident immunizations.<br><br>RN Managers re-educated on the SFHS Vaccination Consent form required as part of admission process to be completed and signed by both resident/resident representative and facility representative as well as offering Vaccine Information Sheet from CDC on vaccines offered.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Weekly audits of all new admissions to ensure we obtain immunization records, provide education, offer the pneumococcal and influenza vaccines, and document declinations will be completed by the Director of Nursing and/or designee beginning the week of 04/13/2026, until compliance is achieved.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation.<br><br>Completion Date: 04/28/2026 | |

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| F0883<br>SS = D | Continued from page 53<br>Findings include:<br><br>R12’s significant change Minimum Data Set (MDS) dated 1/30/26, identified R12 had diagnoses which included malignant neoplasm of right renal pelvis, hypothyroidism, dementia, and hypertension.<br><br>A review of R12’s immunization record identified they received the influenza vaccine on 11/4/25, education given was documented as “no”.<br><br>R13’s comprehensive MDS dated 9/25/25, identified R13 had diagnoses which included atrial fibrillation (fast, irregular heart rate), gastroesophageal reflux disease (GERD), benign prostatic hyperplasia (BPH [noncancerous enlargement of the prostate gland]), hyperlipidemia, arthritis, and depression.<br><br>A review of R13’s Vaccination Consent form dated 9/17/25, identified they wanted to receive the influenza vaccine during the influenza season. There was no evidence R13 was offered the vaccine during the immunization season.<br><br>R8’s quarterly Minimum Data Set (MDS) dated 1/7/26, identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, and post-traumatic stress disorder (PTSD).<br><br>A review of R8’s immunization record identified they received the influenza vaccine on 11/4/25, education given was documented as “no”.<br><br>During an interview on 2/26/26 at 12:18 p.m., the acting director of nursing acting (DON) stated when residents were admitted they received the Vaccine Information Statement (VIS) in their admission packet. The acting DON stated during the flu and cold season they have a vaccine clinic and re-do consents and VIS.<br><br>During an interview on 2/26/26 at 3:36 p.m., the nurse consultant (NC)-B stated when flu season comes around new consents were obtained and new education was given along with a VIS.<br><br>Resident Immunizations dated 1/21/25, identified the facility would offer vaccinations based on the Centers for Disease Control recommendations and physician orders. The policy further identified Vaccine Information Statements would be provided to the resident and/or representative prior to administration of the vaccination. Education would be provided and any questions answered prior to administration of the vaccine and documented in the electronic medical | F0883 | | |

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| F0883<br>SS = D | Continued from page 54<br>record. | F0883 | | |
| F0887<br>SS = D | COVID-19 Immunization<br><br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80 Infection control<br><br>§483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br><br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br><br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br><br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br><br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses.<br><br>(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and<br><br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br><br>(B) Each dose of COVID-19 vaccine administered to the resident, or<br><br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. | F0887 | F: 887 It is Franciscan Health Center's policy to keep residents' immunization records up to date.<br><br>The Director of Nursing will implement corrective action for residents R8 affected by this practice by:<br><br>Resident R8's immunization records were reviewed and updated.<br><br>The Director of Nursing will assess residents having the potential to be affected by this practice including:<br><br>All residents have the potential to be affected by this deficient practice.<br><br>All current residents' immunization status will be evaluated to identify any deficiencies noted.<br><br>The Director of Nursing will implement measures to ensure that this practice does not recur including:<br><br>IDT reviewed the Resident Immunization Policy, Covid-19 Vaccine Policy and processes related to resident immunizations.<br><br>RN Managers re-educated on the SFHS Vaccination Consent form required as part of admission process to be completed and signed by both resident/resident representative and facility representative as well as offering Vaccine Information Sheet from CDC on vaccines offered.<br><br>The Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:<br><br>Weekly audits of all new admissions to ensure we obtain immunization records, provide education, offer the COVID-19, and document declinations will be completed by the Director of Nursing and/or designee beginning the week of 04/13/2026, until compliance is achieved.<br><br>Audit results will be brought to the QAPI committee quarterly for review and further recommendation. | 04/28/2026 |

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| F0887<br>SS = D | Continued from page 55<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br><br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br><br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br><br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to ensure residents were educated on COVID-19 vaccinations when administered to 1 of 5 residents (R8).<br><br>Findings include:<br><br>R8’s quarterly Minimum Data Set (MDS) dated 1/7/26, identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, and post-traumatic stress disorder (PTSD).<br><br>A review of R8’s immunization record identified they received the Covid-19 vaccination on 11/4/25, education given was documented as “no”.<br><br>During an interview on 2/26/26 at 12:18 p.m., the acting director of nursing acting (DON) stated when residents were admitted they received the Vaccine Information Statement (VIS) in their admission packet.<br><br>During an interview on 2/26/26 at 3:36 p.m., the nurse consultant (NC)-B stated when vaccines were given new consents were obtained and new education was given along with a VIS.<br><br>Resident Immunizations dated 1/21/25, identified the facility would offer vaccinations based on the Centers for Disease Control recommendations and physician orders. The policy further identified Vaccine Information Statements would be provided to the resident and/or representative prior to administration of the vaccination. Education would be provided and any questions answered prior to administration of the vaccine and documented in the electronic medical record. | F0887 | Continued from page 55<br><br>Completion Date: 04/28/2026 | |

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| F0887<br>SS = D | | F0887 | | |

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| **Franciscan Health Center** | **3910 MINNESOTA AVENUE , DULUTH, Minnesota, 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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| K0000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/25/2026. At the time of this survey, Franciscan Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.<br><br>Healthcare Fire Inspections<br><br>State Fire Marshal Division<br><br>445 Minnesota St., Suite 145<br><br>St. Paul, MN 55101-5145, OR | K0000 | | 04/28/2026 |

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 reverse for further 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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245258** | (X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING | (X3) DATE SURVEY COMPLETED **02/25/2026** |
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| K0000 | Continued from page 1<br>By email to:<br><br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy.<br><br>The facility was inspected as 1 building:<br><br>Franciscan Health Center Building 01 is a 2 story building with a small partial basement. The 2nd level is all office space with no resident access. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(000) construction. In 1970 an addition was constructed that was determined to also be of Type II(00) construction. In 2006 a one-story addition without a basement was constructed that was determined to be of Type II(000).<br><br>This building is fully fire sprinkler protected. The entire facility has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor.<br><br>The facility has a capacity of 48 beds and had a census of 37 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K0000 | | |
| K0221<br>SS = D | Patient Sleeping Room Doors<br><br>CFR(s): NFPA 101<br><br>Patient Sleeping Room Doors<br><br>Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted | K0221 | K221<br><br>Franciscan Health Center will maintain a clear path to egress<br><br>In order to comply with NFPA 101 (2012 edition), Life Safety Code sections 19.2.1. and 7.1.10.1: | 04/28/2026 |

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| K0221<br>SS = D | Continued from page 2<br>for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5.<br><br>18.2.2.2, 19.2.2.2, TIA 12-4<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/25/2026 at 1:55pm, it was revealed by observation that there were boxes and or debris in the egress corridor outside kitchen.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0221 | Continued from page 2<br><br>The boxes and debris were cleared from the corridor outside the kitchen on 02/25/26.<br><br>The Environmental Service Director completed a tour of the facility and checked all hallways and other areas of egress. The Environmental Service Director was educated on ensuring all corridors need to be free from clutter to allow for egress in an emergency.<br><br>The Environmental Service Director will tour the facility randomly to ensure future compliance.<br><br>The Environmental Service Director is responsible for correction and monitoring to prevent recurrence of the deficiency.<br><br>Completion Date: 04/28/2026 | |
| K0321<br>SS = E | Hazardous Areas - Enclosure<br><br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br><br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br><br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br><br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br><br>a. Boiler and Fuel-Fired Heater Rooms<br><br>b. Laundries (larger than 100 square feet)<br><br>c. Repair, Maintenance, and Paint Shops | K0321 | K321<br><br>Franciscan Health Center will have doors with self-closing devices<br><br>In order to comply with NFPA 101 (2012 edition), Life Safety Code sections 19.3.2.1.3 and 7.2.1.8.1:<br><br>The dry storage room outside the kitchen will have a self-closing device installed by 04/10/2026. RM 217 was cleared out and will not be used for storage going forward.<br><br>The Environmental Service Director completed a tour of the facility and checked all other storage rooms for self-closing devices. The Environmental Service Director was educated in ensuring all storage room doors have self-closing devices on them.<br><br>The Environmental Service Director will tour the facility randomly to ensure future compliance.<br><br>The Environmental Service Director is responsible for correction and monitoring to prevent recurrence of the deficiency. | 04/28/2026 |

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| K0321<br>SS = E | Continued from page 3<br><br>d. Soiled Linen Rooms (exceeding 64 gallons)<br><br>e. Trash Collection Rooms<br><br>(exceeding 64 gallons)<br><br>f. Combustible Storage Rooms/Spaces<br><br>(over 50 square feet)<br><br>g. Laboratories (if classified as Severe<br><br>Hazard - see K322)<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/25/2026 at 1:59pm, it was revealed by observation that the dry storage room located outside the kitchen did not have a self-closing device.<br><br>On 02/24/2026 at 2:15pm, it was revealed by observation that a patient room (RM 217) that is being used for storage did not have a self-closing device.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0321 | Continued from page 3<br><br>Completion Date: 04/28/2026 | |
| K0345<br>SS = D | Fire Alarm System - Testing and Maintenance<br><br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br><br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br><br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation and staff | K0345 | K345<br><br>Franciscan Health Center will have appropriate testing and maintenance of the fire alarm system.<br><br>In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 9.6.1.3 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.2.1.2.2:<br><br>Annual fire alarm testing for sensitivity was completed on 02/20/2026.<br><br>The Environmental Service Director (ESD) was trained in | 04/28/2026 |

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| K0345<br>SS = D | Continued from page 4<br>interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/25/2026, at 1:01pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Northern Fire Protection on 02/20/2026 that the facility could not provide documentation that a sensitivity testing had been conducted. .<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0345 | Continued from page 4<br>the requirements of annual sensitivity testing.<br><br>Administrator will audit to ensure future compliance.<br><br>The Environmental Service Director is responsible for correction and monitoring to prevent recurrence of the deficiency.<br><br>Completion Date: 04/28/2026 | |
| K0363<br>SS = D | Corridor - Doors<br><br>CFR(s): NFPA 101<br><br>Corridor - Doors<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.<br><br>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. | K0363 | K363<br><br>Franciscan Health Center will have doors that latch properly.<br><br>In order to comply with NFPA 101 (2012 Edition), Life Safety Code sections 19.3.6.3.5:<br><br>Room 209 door was adjusted so it latched properly, and the door handle was repaired on 02/24/2026.<br><br>The Environmental Service Director completed a tour of the facility and checked all other doors for proper latching. The Environmental Service Director was educated to ensure all doors latch properly.<br><br>The Environmental Service Director will tour the facility randomly to ensure future compliance.<br><br>The Environmental Service Director is responsible for correction and monitoring to prevent recurrence of the deficiency.<br><br>Completion Date: 04/28/2026 | 04/28/2026 |

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| K0363<br>SS = D | Continued from page 5<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br><br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/25/2026 at 2:05pm, it was revealed by observation that the resident room door 209 does not latch and has a defective door handle.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0363 | | |
| K0914<br>SS = F | Electrical Systems - Maintenance and Testing<br><br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br><br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br><br>6.3.4 (NFPA 99)<br><br>This STANDARD is NOT MET as evidenced by: | K0914 | K914<br><br>Franciscan Health Center will have receptacle testing per regulation<br><br>In order to comply with NFPA 99 (2012 edition), Standards for Health Care Facilities, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2:<br><br>Receptacle inspection will be completed by 03/06/2026. Replacement was completed on 03/12/2026.<br><br>The Environmental Service Director (ESD) was educated on the importance of completing receptacle inspection and having documentation readily available.<br><br>The Administrator will monitor to ensure future compliance.<br><br>The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent recurrence of the deficiency. | 04/28/2026 |

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| K0914<br>SS = F | Continued from page 6<br>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 02/25/2026 at 1:32pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. Last electrical test was done on 02/03/2025.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0914 | Continued from page 6<br>Completion Date: 04/28/2026 | |
| K0918<br>SS = D<br>Bldg. 01 | Electrical Systems - Essential Electric Syste<br><br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br><br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br><br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. | K0918 | K918<br><br>Franciscan Health Center will have its emergency generator properly maintained and serviced<br><br>In order to comply with NFPA 110 (2010 edition) Standard for Emergency and Standby Power Systems, section 4.2:<br><br>Allied Generator inspected the generator and checked the fuel on 03/13/2026 the test failed and the fuel will be remedied by 04/10/2026.<br><br>The Environmental Service Director (ESD) was educated on ensuring generator fuel testing be completed annually with our annual maintenance and that documentation is placed in Fire Book, so it is available during LSC survey.<br><br>The Administrator will monitor to ensure future compliance.<br><br>The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent recurrence of the deficiency.<br><br>Completion Date: 04/28/2026 | 04/28/2026 |

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| K0918<br>SS = D<br>Bldg. 01 | Continued from page 7<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. This deficient finding could have an isolated on the residents within the facility.<br><br>Findings include<br><br>On 02/25/2026 at 13:42pm, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability and/or a fuel testing document from a fuel company.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K0918 | | |