DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3GUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00865

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245258**

2.STATE VENDOR OR MEDICAID NO.
(L2) **551218200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRANCISCAN HEALTH CENTER**
(L4) **3910 MINNESOTA AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2012** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
__X__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A , 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Pat Halverson, Unit Supervisor 04/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 04/06/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/16/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5258
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 3, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit by review of the plan of correction. Based on the plan of correction, it has been determined that the facility had achieved substantial compliance pursuant to the standard survey completed on February 3, 2012, effective March 5, 2012. Therefore, the remedies outlined in our letter dated February 15, 2012 will not be imposed. See attached CMS-2567b for the results of the March 19, 2012 revisit.

Documentation supporting the facility's request for a continuing waiver involving K55 was previously forwarded. Approval of the waiver request was recommended.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5258

April 6, 2012

Mr. Robert Dahl, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, Minnesota 55802

Dear Mr. Dahl:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 5, 2012 the above facility is recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 6, 2012

Mr. Robert Dahl, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, Minnesota 55802

RE: Project Number S5258021

Dear Mr. Dahl:

On February 15, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 3, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 3, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 5, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 3, 2012, effective March 5, 2012 and therefore remedies outlined in our letter to you dated February 15, 2012, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5258R12.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245258	A. Building B. Wing	3/19/2012

Name of Facility	Street Address, City, State, Zip Code
FRANCISCAN HEALTH CENTER	3910 MINNESOTA AVENUE DULUTH, MN 55802

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/05/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/05/2012**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/05/2012**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/05/2012**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/05/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/05/2012**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/05/2012**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/05/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/05/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/05/2012**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **03/05/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PH/NCS	4/6/12	12835	3/19/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/3/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3GUP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00865

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245258**

2.STATE VENDOR OR MEDICAID NO.
(L2) **551218200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FRANCISCAN HEALTH CENTER**
(L4) **3910 MINNESOTA AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/03/2012** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** 5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cynthia Green - HFE-NEII 03/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/14/2012 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Sent to RO on 3/20/2012 ML

Posted 3/20/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5258
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 3, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility¿s request for a continuing waiver involving the deficiency cited at K55 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 0398

February 15, 2012

Mr. Robert Dahl, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, Minnesota 55802

RE: Project Number S5258021

Dear Mr. Dahl:

On February 3, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637

Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 14, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 14, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 3, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 3, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File 5258S12.rtf

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	02/03/2012

RECEIVED
FEB 26 2012
UM Dept of Health Duluth

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Resident census: 40	F 000	OK with addendums 3/2/12 RLN See attached addendum all completion dates 3/5/2012	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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

Administrator — 2-27-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	02/03/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility failed to adequately investigate and/or promptly report incidents of potential mistreatment to the administrator/state agency for 11 of 14 residents (R22, R43, R3, R17, R19, R25, R4, R45, R46, R10, R11) reviewed for potential mistreatment. Findings included: The Abuse Prevention Plan dated as reviewed/revised in January 2012, indicated that resident to resident abuse was reportable if the act was intentional, or if unable to determine it was non-intentional, or if it involves serious injury. Reportable incidents were to be reported to the state agency via the on-line reporting system. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness with a negative outcome to the resident. If in failing to	F 225	See PoC page 2-a	

FHC POC
F225 VA-INVESTIGATE/REPORT ALLEGATIONS
FHC ensures that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures.
Over the last 13 months since last survey, a small number of incidents were not reported in a timely manner for various reasons. When Administrative staff became aware of an incident that could be a potential VA issue, it was immediately reported and staff were retrained and/or disciplined, as appropriate.
Since the January 17, 2012 MDH statewide regulatory call, with clarification of interpretation of 'immediately, (no longer 'within 24 hrs' as previously understood), all reports have been reported immediately,(as soon as determine what happened and if is reportable or not) to the Administrator, and to the State Agency.
The facility **Abuse Prohibition Policy** was reviewed and revised, including 'res to res altercations' updated to exact language under Federal Regulation F323. Also added to 'notify Administrator immediately' under each type of reportable incident.
Reports to State completed on resident 22 from 11-28-2011 1-1-2-12 and 1-14-2012 on February 21, 2012
Staff re-education on Potential mistreatment and Reporting guidelines:
Management staff were re-educated on 2-6-2012
Individual training for staff was held during the Week of 2-6-2012 to 2-13-2012
Meetings held: Licensed staff were educated on 2-27-2012
Mandatory all-staff training on reporting incidents of potential mistreatment was held on 3-1-2012
All Progress notes and incident reports will be monitored on a daily basis (Supervising Nurse on weekends and IDT on week days), to ensure all incidents of potential mistreatment, abuse or neglect are being followed up on appropriately. Staff re-educated on the need to call supervisor on day of incident/issue so reporting can be done timely.
Random audits of incident reports will be conducted daily x 2 weeks Then 3 x per week x 4 by either the Administrator, Assistant Administrator, DON/designee

Audit results will be brought forward to the QA Committee for review and any further recommendations.
Completion date: 3-5-2012

page 2-a

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F 225	Continued From page 2 follow the plan of care a negative outcome occurs, it is neglect. This would include medication omission or medication mistakes that are harmful. The policy section regarding investigation of accident/incidents indicated that "A comprehensive initial investigation must be completed immediately and a decision made if need to notify MDH and/or the facility's common entry point by the person who receives the initial report." R22 had falls where the care plan was not followed. The potential neglect was not immediately reported to the state agency. R22's diagnosis included Parkinsonism, osteoarthritis, joint pain, hallucinations and dementia with Lewy bodies syndrome. The annual Minimum Data Set (MDS) dated 12/28/11, indicated R22 had moderately impaired cognition, and required extensive assistance of 2 staff for bed mobility, transfers, ambulation in room, and toileting. The comprehensive fall risk assessment, dated 12/19/11 (not approved) did not include the author's name. The indicated R22 was at high risk for falls, and interventions to reduce risk for falls included the following: pressure alarms in place in wheelchair, recliner and bed, seat belt alarm, signage on walls, grab bar on bed, dysem in chair and under recliner chair, wrist call light in place, no bedside tables with wheels, grip socks on at night, proper footwear during the day and toileting program. R22's progress notes indicated the following falls: On 11/28/22 at 2:30 p.m., R22 fell in his room	F 225		

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F 225	Continued From page 3 and sustained two bruises/abrasions to the right forehead. The alarm was not sounding. There was no investigation to determine if the care plan was followed and no report to the state agency. The progress note dated 1/2/12 (not approved) was a review of a fall on 1/1/12. On 1/1/12 at 11:45 p.m., R22 fell in his room, the alarms were not hooked up properly as directed by the care plan. The fall was not reported to the state agency despite the care plan not being followed. On 1/14/12 at 12:00 a.m., R22 was not wearing grip socks as directed by the plan of care when he fell in his room. R22 sustained a 1.8 centimeter (cm) skin tear/laceration to the top of his head and a skin tear to the left elbow/forearm region. The fall with injury with the care plan not followed was not reported to the state agency. On 2/2/12 at 9:01 a.m., the registered nurse manager (RN-C) was interviewed and stated falls should be reported to the state agency if there are any injuries such as cuts, bruises, skin tears and pain, and when staff did not follow the care plan. R43 had falls that were not appropriately investigated or reported as directed by facility policy. R43 fell out of bed on 1/30/12. Documentation describing the fall was written by staff not present at the time of the fall, the care plan was not followed, and the incident was not reported to the state agency. R43 had diagnoses which included dementia with	F 225		

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F 225	Continued From page 4 psychosis and anxiety. The Comprehensive fall risk assessment dated 5/23/11 identified R43 at high risk for falls. Interventions to reduce the risk for falls included: a hi-low bed, wandergaurd alarm, and proper footwear or non-skid stockings in place at all times. The quarterly Minimal Data Set (MDS) dated 11/29/11, indicated R43 had severe cognitive impairment and needed extensive assist with activities of daily living (ADL's) except for eating which was limited assist. The Fall Scene Investigation tool on 1/30/12, at 5:35 am indicated R43 was found half on the bed with his arm resting on the pressure alarm, preventing the alarm from sounding. The document indicated that nursing assistants found R43 at the time of the incident and the document was signed as completed by a nursing assistant. The registered nurse manager (RN)-A, interviewed at 8:43 a.m. on 2/1/12, stated that, although she was not present at the time of the incident, she completed the Fall Scene Investigation Tool and signed the nursing assistant's name to the document. RN-A stated that R43 should have been wearing non-skid footwear at all times as directed by the plan of care. RN-A did not identify the failure to follow the plan of care when she completed the Post Fall Investigation. RN-A stated the incident had not been reported to the state agency. R3 fell from a PAL standing lift on 10/23/11. The immediate incident investigation indicated the incident was reportable because the care plan was not followed. The incident was not reported	F 225		

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F 225	Continued From page 5 to the state agency or administrator until 10/24/11. The incident report dated 10/23/11 at 7:45 pm, indicated that R3 fell from the PAL standing lift. The incident was witnessed. The incident report areas for notification of DON/Admin/physician were all blank. The Fall Scene Investigation Tool dated 10/23/11 indicated that the care plan directed transfer by two staff; however, only one staff was present when R3 fell from the PAL standing lift. The investigation indicated R3's family was notified at 8:30 pm on 10/23/11. An entry (no time, date or signature) at the end of the Post Fall Investigation indicated the incident was reportable because the care plan was not followed. The Vulnerable Adult/Child Investigation/Written Report was initiated on 10/24/11, and indicated the care plan was not followed. There was no evidence of reporting to the state agency or administrator until sometime on 10/24/11 (time of the report not documented). The social worker (SW)-A, interviewed at approximately 1:30 pm on 2/1/12, verified that R3's fall from the standing lift was not reported immediately despite documentation that staff were aware the care plan had not been followed. The charge nurse working at the time of the incident did not immediately report the fall to the administrator, DON or state agency. R17 fell when a Hoyer lift tipped over on 2/28/11. The Fall Scene Investigation indicated that the Hoyer lift tipped over during a transfer at 8:30 pm on 2/28/11. The Fall Scene Investigation did not indicate any potential causative factors such as	F 225		

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F 225	Continued From page 6 the condition of the lift and sling or if the sling was correctly hooked up. The Post Fall Investigation at 9:00 pm on 2/28/11, indicated, "After interviewing several CNAs it appears that the Hoyer Lifts that we use are not adequate to use on this res (resident). Also the CNAs involved did not use proper procedure." The lift was taken out of service. The incident was not reported to the state agency until 3/2/11. SW-A, interviewed at approximately 1:30 pm on 2/1/12, verified the incident was not reported within 24 hours. R19 and R25 had an altercation on 8/26/11 that was not reported to the state agency until 8/29/11. Progress notes on 8/26/11 at 8:00 pm indicated that R19 was trying to exit the dining room and bumped the back of R25's wheelchair. R25 backed up the wheelchair and blocked R19's exit from the dining room. R19 was upset and struck R25 on the back of the head with her hand. Progress notes on 8/26/11 at 8:22 pm indicated that R25 was at the dining room table when the back of his wheelchair was bumped by R19. R25 backed his chair into the path of R19 blocking her path. R25 was struck on the back of the head by R19. The resident to resident altercation between R19 and R25 was not reported to state agency until 8/29/11. SW-A, interviewed at approximately 1:30 pm on 2/1/12, stated the incident occurred on a Friday evening and was not reported to the state agency until the following Monday. R4 was not provided physician ordered dressing	F 225		

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F 225	Continued From page 7 changes on 6/11 and 6/12/11. The potential mistreatment was not reported to the state agency until 6/16/11. The Vulnerable Adult/Child Investigation/Written Report indicated that R4 was not provided physician ordered dressing changes on 6/11/11 and 6/12/11. R4 returned from the wound clinic with new wound care orders on 6/9/11. Dressing supplies were ordered on Friday, 6/10/11, but did not arrive by the end of the day. No one followed up to ensure the appropriate dressing supplies were available for the weekend. On 6/13/11, the registered nurse found the dressing had not been changed since R4 returned from the wound clinic on 6/9/11. An investigation into the lack of dressing changes was initiated on 6/13/11 and the incident was not reported to the state agency until 6/16/11. SW-A, interviewed at approximately 1:30 pm on 2/1/12, verified R4's treatments were not provided on the weekend of 6/11 and 6/12/11. The lack of treatment provided was not reported to the state agency until 6/16/11. R45 was hit on the head by R46 on 1/1/12. The resident to resident physical altercation was not reported to the state agency until 1/3/12. Nursing notes on 1/1/12, at 9:15 pm indicated that R46 hit R45 on the back of the head with an open palm. The note indicated that R46 told staff to "bring me back to (R45) so I can beat her ass." The Vulnerable Adult/Child Investigation/Written Report indicated that an investigation was initiated on 1/2/12 or 1/3/12 (3 and 2 written one over the other with both dates legible) and the incident was reported to the state agency on	F 225		

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F 225	Continued From page 8 1/3/12. The assistant administrator (AA) provided a written statement on 2/2/12 at 10:00 am that indicated she attempted to contact the state agency on 1/2/12 but was unable to access the web site until 1/3/12. There was no evidence to support the attempted notification on 1/2/12. SW-A, interviewed at approximately 1:30 pm on 2/1/12, stated that the incident occurred on a weekend and was not reported until the following Tuesday. R10 and R11 had a verbal altercation on 10/15/11. The resident to resident altercation was not reported to the state agency until 10/17/11. Nursing notes on 10/15/11, at 10:30 pm indicated that R11 yelled at R10, "If I ever get ahold of that son of a bitch I am going to punch him as hard as I can right in the face, that dirty bastard." R10 wheeled up to R11 and raised his fist and stated, "if you want to fight let's go, cause I will beat you to a pulp." The residents were separated. The Vulnerable Adult/Child Investigation/Written Report indicated that an investigation was initiated on 10/17/11 and the incident was reported to the state agency on 10/17/11. There was no documentation to indicate the administrator was notified before 10/17/11. The AA provided documentation at on 2/2/12 at 10:00 am that indicated the witness reported the incident to the team leader; however, the team leader did not report the incident to the DON or AA or administrator. SW-A, interviewed at approximately 1:30 pm on 2/1/12, stated that the incident occurred on a weekend and was reported late.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 9 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility failed to implement policies and procedures related to reporting incidents of potential mistreatment to the administrator/state agency for 11 of 14 residents (R22, R43, R3, R17, R19, R25, R4, R45, R46, R10, R11) reviewed for potential mistreatment. Findings included: The Abuse Prevention Plan dated as reviewed/revised in January 2012, indicated that resident to resident abuse was reportable if the act was intentional, or if unable to determine it was non-intentional, or if it involves serious injury. Reportable incidents were to be reported to the state agency via the on-line reporting system. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness with a negative outcome to the resident. If in failing to follow the plan of care a negative outcome occurs, it is neglect. This would include medication omission or medication mistakes that are harmful. The policy section regarding investigation of accident/incidents indicated that "A comprehensive initial investigation must be completed immediately and a decision made if need to notify MDH and/or the facility's common entry point by the person who receives the initial	F 226	Revised POC page 10a F226 VA = P&P FHC has developed and implements written policies and procedures that prohibit mistreatment, neglect and abuse of facility residents. When involved week-end staff did not report a potential incident to Administration immediately, staff were re-educated and disciplined as appropriate. Administrative staff reported the incidents to the State Agency as soon as became aware of it and determined the incident to be reportable. On survey on 1/31/12, surveyor1 interviewed R_27 who indicated staff had been rough with him a couple weeks prior to that time. Surveyor1 did not report this to facility Administration until 2/1/12. When reported to the facility Staff by surveyor it was immediately reported to the State and CEP. Investigation followed. All supervisory Nursing staff received re-education on reporting incidents immediately, on 2-6-2012 and 2-27-2012 The Abuse Prohibition P&P was reviewed and revised. All staff received mandatory training on the facility Abuse P&P related to reporting incidents of potential mistreatment to the Administrator and to the State Agency, on 2/27/12. Completion date: 3-5-2012 Random audits of Incident reports will be conducted 3 x per week x 4 by either the Administrator, Assistant Administrator, DON/designee Audit results will be brought forward to the QA Committee for review and any further recommendations. Completion date: 3-5-2012	

F226 VA = P&P
FHC has developed and implements written policies
and procedures that prohibit mistreatment, neglect
and abuse of facility residents.
When involved week-end staff did not report a potential
incident to Administration immediately, staff were
re-educated and disciplined as appropriate.
Administrative staff reported the incidents to the State
Agency as soon as became aware of it and determined
the incident to be reportable.
All supervisory Nursing staff received re-education on
reporting incidents immediately, on 2-6-2012 and 2-27-2012
The Abuse Prohibition P&P was reviewed and revised.
All staff received mandatory training on the facility Abuse
P&P related to reporting incidents of potential mistreatment
to the Administrator and to the State Agency, on 2/27/12.
Completion date: 3-5-2012
Random audits of incident reports will be conducted daily x 2 weeks
Then 3 x per week x 4 by either the Administrator, Assistant Administrator,
DON/designee

Audit results will be brought forward to
the QA Committee for review and any further
recommendations.
Completion date: 3-5-2012

F250

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F 226	Continued From page 10 report." The facility abuse prevention policy was not implemented in regard to investigation and reporting of falls for R22. R22's diagnosis included Parkinsonism, osteoarthritis, joint pain, hallucinations and dementia with Lewy bodies syndrome. The annual Minimum Data Set (MDS) dated 12/28/11, indicated R22 had moderately impaired cognition, and required extensive assistance of 2 staff for bed mobility, transfers, ambulation in room, and toileting. The comprehensive fall risk assessment, dated 12/19/11 (not approved) and there is no identified author, indicated R22 was at high risk for falls, and interventions to reduce risk for falls included the following: pressure alarms in place in wheelchair, recliner and bed, seat belt alarm, signage on walls, grab bar on bed, dysem in chair and under recliner chair, wrist call light in place, no bedside tables with wheels, grip socks on at night, proper footwear during the day, and toileting program. R22's progress notes indicated the following falls: On 11/28/22 at 2:30 p.m., R22 fell in his room and sustained two bruises/abrasions to the right forehead. The alarm was not sounding. There was no investigation to determine if the care plan was followed and no report to the state agency. The progress note dated 1/2/12 (not approved) was a review of a fall on 1/1/12. On 1/1/12 at 11:45 p.m., R22 fell in his room, the alarms were not hooked up properly as directed by the care	F 226		

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F 226	Continued From page 11 plan. The fall was not reported to the state agency despite the care plan not being followed. On 1/14/12 at 12:00 a.m., R22 was not wearing grip socks as directed by the plan of care when he fell in his room. R22 sustained a 1.8 centimeter (cm) skin tear/laceration to the top of his head and a skin tear to the left elbow/forearm region. The fall with injury with the care plan not followed was not reported to the state agency. On 2/2/12 at 9:01 a.m., the registered nurse manager (RN-C) was interviewed and stated falls should be reported to the state agency if there are any injuries such as cuts, bruises, skin tears and pain, and when staff did not follow the care plan. R43 had falls that were not appropriately investigated or reported as directed by facility policy. R43 fell out of bed on 1/30/12. The documentation regarding potential causative factors was inconsistent and the incident was not reported as potential neglect of healthcare despite the care plan not being followed. R43 had diagnoses which included dementia with psychosis and anxiety. The Comprehensive fall risk assessment dated 5/23/11 identified R43 at high risk for falls. Interventions to reduce the risk for falls included: a hi-low bed, wandergaurd alarm, and proper footwear or non-skid stockings in place at all times. The quarterly Minimal Data Set (MDS) dated 11/29/11, indicated R43 had severe	F 226		

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F 226	Continued From page 12 cognitive impairment and needed extensive assist with activities of daily living (ADL's) except for eating which was limited assist. The Fall Scene Investigation tool on 1/30/12, at 5:35 am indicated R43 was found half on the bed with his arm resting on the pressure alarm, preventing the alarm from sounding. The document indicated that nursing assistants found R43 at the time of the incident and the document was signed as completed by a nursing assistant. The registered nurse manager (RN)-A, interviewed at 8:43 a.m. on 2/1/12, stated that, although she was not present at the time of the incident, she completed the Fall Scene Investigation Tool and signed the nursing assistant's name to the document. RN-A stated that R43 should have been wearing non-skid footwear at all times as directed by the plan of care. RN-A did not identify the failure to follow the plan of care when she completed the Post Fall Investigation. RN-A stated the incident had not been reported to the state agency. R3 fell from a PAL standing lift on 10/23/11. The immediate incident investigation indicated the incident was reportable because the care plan was not followed. The incident was not reported to the state agency or administrator until 10/24/11. The incident report dated 10/23/11 at 7:45 pm, indicated that R3 fell from the PAL standing lift. The incident was witnessed. The incident report areas for notification of DON/Admin/physician were all blank. The Fall Scene Investigation Tool dated 10/23/11 indicated that the care plan	F 226		

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F 226	Continued From page 13 directed transfer by two staff; however, only one staff was present when R3 fell from the PAL standing lift. The investigation indicated R3's family was notified at 8:30 pm on 10/23/11. An entry (no time, date or signature) at the end of the Post Fall Investigation indicated the incident was reportable because the care plan was not followed. The Vulnerable Adult/Child Investigation/Written Report was initiated on 10/24/11, and indicated the care plan was not followed. There was no evidence of reporting to the state agency or administrator until sometime on 10/24/11 (time of the report not documented). The social worker (SW)-A, interviewed at approximately 1:30 pm on 2/1/12, verified that R3's fall from the standing lift was not reported immediately despite documentation that staff were aware the care plan had not been followed. The charge nurse working at the time of the incident did not immediately report the fall to the administrator, DON or state agency. R17 fell when a Hoyer lift tipped over on 2/28/11. The Fall Scene Investigation indicated that the Hoyer lift tipped over during a transfer at 8:30 pm on 2/28/11. The Fall Scene Investigation did not indicate any potential causative factors such as the condition of the lift or the sling at the time. The Post Fall Investigation at 9:00 pm on 2/28/11, indicated, "After interviewing several CNAs it appears that the Hoyer Lifts that we use are not adequate to use on this res (resident). Also the CNAs involved did not use proper procedure." The lift was taken out of service. The incident was not reported to the state agency until 3/2/11. SW-A, interviewed at approximately 1:30 pm on	F 226		

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F 226	Continued From page 14 2/1/12, verified the incident was not reported within 24 hours. R19 and R25 had an altercation on 8/26/11 that was not reported to the state agency until 8/29/11. Progress notes on 8/26/11 at 8:00 pm indicated that R19 was trying to exit the dining room and bumped the back of R25's wheelchair. R25 backed up the wheelchair and blocked R19's exit from the dining room. R19 was upset and struck R25 on the back of the head with her hand. Progress notes on 8/26/11 at 8:22 pm indicated that R25 was at the dining room table when the back of his wheelchair was bumped by R19. R25 backed his chair into the path of R19 blocking her path. R25 was struck on the back of the head by R19. The resident to resident altercation between R19 and R25 was not reported to state agency until 8/29/11. SW-A, interviewed at approximately 1:30 pm on 2/1/12, stated the incident occurred on a Friday evening and was not reported to the state agency until the following Monday. R4 was not provided physician ordered dressing changes on 6/11 and 6/12/11. The potential mistreatment was not reported to the state agency until 6/16/11. The Vulnerable Adult/Child Investigation/Written Report indicated that R4 was not provided physician ordered dressing changes on 6/11/11 and 6/12/11. R4 returned from the wound clinic with new dressing change directions on 6/9/11.	F 226		

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F 226	Continued From page 15 Dressing supplies were ordered on 6/10/11 but did not arrived by the end of the day. No one followed up to ensure the supplies were available for the weekend. On 6/13/11, the registered nurse found the dressing had not been changed since R4 returned from the wound clinic on 6/9/11. An investigation into the lack of dressing changes was initiated on 6/13/11 and the incident was not reported to the state agency until 6/16/11. SW-A, interviewed at approximately 1:30 pm on 2/1/12, verified R4's treatments were not provided on the weekend of 6/11 and 6/12/11. The lack of treatment provided was not reported to the state agency until 6/16/11. R45 was hit on the head by R46 on 1/1/12. The resident to resident physical altercation was not reported to the state agency until 1/3/12. Nursing notes on 1/1/12, at 9:15 pm indicated that R46 hit R45 on the back of the head with an open palm. The note indicated that R46 told staff to "bring me back to (R45) so I can beat her ass." R46 requested a baseball bat from staff after informing them of a previous assault with a baseball bat. The Vulnerable Adult/Child Investigation/Written Report indicated that an investigation was initiated on 1/2/12 or 1/3/12 (3 and 2 written one over the other with both dates legible) and the incident was reported to the state agency on 1/3/12. The assistant administrator (AA) provided a written statement on 2/2/12 at 10:00 am that indicated she attempted to contact the state agency on 1/2/12 but was unable to access the web site until 1/3/12. There was no evidence to support the attempted notification on 1/2/12. SW-A, interviewed at approximately 1:30	F 226		

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F 226	Continued From page 16 pm on 2/1/12, stated that the incident occurred on a weekend and was not reported until the following Tuesday. R10 and R11 had a verbal altercation on 10/15/11. The resident to resident altercation was not reported to the state agency until 10/17/11. Nursing note on 10/15/11, at 10:30 pm indicated that R11 yelled at R10, "If I ever get ahold of that son of a bitch I am going to punch him as hard as I can right in the face, that dirty bastard." R10 wheeled up to R11 and raised his fist and stated, "if you want to fight let's go, cause I will beat you to a pulp." The residents were separated. The Vulnerable Adult/Child Investigation/Written Report indicated that an investigation was initiated on 10/17/11 and the incident was reported to the state agency on 10/17/11. There was no documentation to indicate the administrator was notified before 10/17/11. The AA provided documentation at on 2/2/12 at 10:00 am that indicated the witness reported the incident to the team leader; however, the team leader did not report the incident to the DON or AA or administrator. SW-A, interviewed at approximately 1:30 pm on 2/1/12, stated that the incident occurred on a weekend and was reported late.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		

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F 250	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medically related social services were provided for 1 of 1 residents (R5) in the sample reviewed for communication. Findings include: R5 was not provided social services in regard to difficulty with verbal communication. R5's diagnosis included CVA (stroke) with hemiplegia (weakness) and problem with communication. The significant change Minimum Data Set (MDS) dated 11/29/11, indicated an interview for cognitive status could not be completed on R5 because "resident is rarely/never understood." A staff interview for cognitive status was completed at that time and indicated R5 was cognitively intact. The plan of care dated 10/18/11, indicated R5 had difficulty expressing verbally due to aphasia (a loss of ability to express speech). At 9:15 a.m. on 1/31/12, the social worker (SW-A) was interviewed and stated R5 could answer yes/no questions and used gestures for communication. At 7:35 a.m. on 2/1/12, R5 was interviewed and asked if the facility had ever tried a communication board. R4 shook her head and said "no." R5 was asked if she thought a communication board might help her tell staff what she needed, and she nodded her head and	F 250	F250 FHC provides medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. As per R5's POC, R5 does answer yes/no questions and uses gestures for communication. A communication board was provided for the resident and it is in her nightstand, however the resident has consistently refused to use it. New NA staff are educated by experienced NA staff when accompany experienced staff when taking care of R5, until R5 is ready to allow them to care for her alone. R5's Care Plan was updated to reflect current communication status and staff education on res' communication needs. All residents who cannot communicate with staff and would Benefit from a Speech Eval/communication board will be Evaluated to prevent any further communication problems A P/O for another SLP eval and treat was obtained on 2-24-2012. Per SLP Random audits of newly admitted residents with communication Problems and current residents will be completed 3x a week by Assistant Administrator, DON /designee and Social Services with Results brought to the QA committee for further follow up and Recommendations. Completion date: 3-5-2012	

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F 250	Continued From page 18 said "yes." When asked if she would be willing to try a communication board, R5 nodded her head and said "yes." At 12:11 p.m. on 2/1/12, SW-A stated R5 has a communication board in her room, but refuses to use it. SW-A also stated R5 refused to work with speech therapy on admission in January 2009. SW-A stated that new staff are not provided education regarding communication with R5. At 1:25 p.m. on 2/2/12, SW-A took an 8 X 11 inch green laminated page from the nightstand and stated it was R5's communication board. The laminate page had 17 phrases typed on it. At 3:21 p.m. on 2/2/12, nursing assistant A (NA-A) was interviewed and stated R5 communicates with gestures, pointing and one word directions. At 3:24 p.m. on 2/2/12, NA-D was interviewed and stated communication with R5 can be difficult for new staff. R5 does not allow new staff in the room alone with her, and an experienced staff has to be with new staff when they go into R5's room. At 3:26 p.m. on 2/2/12, licensed practical nurse E (LPN-E) was interviewed and stated he has had a difficult time understanding R5. LPN-E often has to tell R5 "I don't understand what you need" and this "upsets" her. A review of the quarterly care conference summaries signed by SW-A and dated 1/5/11, 3/29/11, 6/8/11, 9/7/11, and 12/6/11 (not approved), lacked any indication R5's speech problems or communication was addressed. A	F 250		

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F 250	Continued From page 19 fax dated 2/6/12, included a copy of the quarterly care conference summary for 12/6/11. The fax version of the summary was still dated 12/6/11, the summary was "approved," and had been altered to include, "Resident continues to refuse to use communication board and refuses to work with SLP (Speech Language Pathology) R&B (risks and benefits) completed with resident." The assistant administrator, interviewed at approximately 2:30 pm on 2/2/12, stated that the electronic medical record allows staff to leave an entry open if they are interrupted or called away before the note is complete. The original author can re-enter the note at a later time to finish the documentation and sign off by "approving" the note. EMR entries are not authenticated until they are "approved."	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 R35s Care Plan was reviewed and revised to reflect ADL status for Bed mobility, Locomotion off the unit, Dressing, Toileting and Personal Hygiene. Nursing staff retrained on process for updating Care Plans on 2-6-2012 and education provided to all licensed staff on 2-27-2012 All resident's Care Plans will be reviewed and revised prn when assessment is completed on a Quarterly basis. Audits will be completed by the DON/Nurse Managers And Social Services Random Care Plan audits will be completed 3XwkX4, then wklyX4, then monthly thereafter. Audit results will be brought to the QA committee for review and any further recommendations. Completion date: 3-5-2012	

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F 280	Continued From page 20	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility did not ensure the care plan was reviewed and revised for 1 of 16 residents R35 in the sample whose care plans were reviewed.

Findings include:

R35 had decline in ability for self care for bed mobility, locomotion off the unit, dressing, toilet use and personal hygiene; however, the care plan was not revised to reflect the changes in care needs.

R35's diagnoses included ileostomy/ischemic bowel disease, degenerative joint disease, chronic pain syndrome. Fibromyalgia, congestive heart failure, atrial fibrillation, migraine headaches, osteoarthritis and depression.

The quarterly minimum data set (MDS) completed on 1/11/12, indicated R35 had a decline in bed mobility, locomotion off the unit, dressing, toilet use and personal hygiene. The quarterly MDS dated 10/12/11, indicated R35 was independent in bed mobility, locomotion off the unit, toilet use and personal hygiene and required supervision with dressing. On the quarterly MDS dated 1/11/11, R35 required extensive assistance with bed mobility, locomotion off the unit, dressing and toilet use, and limited assistance with personal hygiene.

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F 280	Continued From page 21 The functional assessment progress note dated 1/3/12, indicated R35 had pain during the assessment reference period (ARD) which had some limiting effects with range of motion (ROM) and activities of daily living (ADL). Per staff interview, R35 required extensive assistance with dressing more than three times during the ARD. R35 required the assistance of one staff to perform pericares after elimination due to stiffness. R35 required extensive assistance for bed mobility more than three times during the ARD due to needing assistance with lifting her legs in and out of bed. R35 required extensive assistance more than three times for wheelchair mobility in the hallway to reach the beauty shop and move through the hallway with her family. R35's care plan had an effective date of 12/1/11, and was not revised to reflect the change in required assistance. The bed mobility care plan indicated R35 was independent with bed mobility. The dressing care plan indicated R35 required limited assistance with dressing her lower body and independent in dressing her upper body. The elimination care plan indicated R35 was independent with toileting. The wheelchair mobility care plan indicated R35 utilized a wheelchair when fatigued and was independent with self propelling. The registered nurse manager (RNM)-A, interviewed at 2:30 p.m. on 2/1/12, stated the level of care required was determined by the nursing assistant (NA) charting during the ARD period. If there was a discrepancy she talked to the staff and tried to figure out why.	F 280		

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F 280	Continued From page 22 The facility's quarterly review of care plans policy revised 8/06, indicated the resident's care plan shall be reviewed at least quarterly. The care planning/interdisciplinary team was responsible for maintaining care plans on current status.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure a communication board was used for 1 of 1 residents (R5) in the sample reviewed for communication. Findings include: R5 was not able to communicate verbally with staff, and the communication board in her room was not utilized. R5's diagnosis included CVA (stroke) with hemiplegia (weakness) and problem with communication. The significant change Minimum Data Set (MDS) dated 11/29/11, indicated an interview for cognitive status could not be completed on R5 because "resident is rarely/never understood." A staff interview for cognitive status was completed at that time and indicated R5 was cognitively intact. The plan of care dated 10/18/11, indicated R5 had difficulty expressing verbally due to aphasia (a loss of	F 311	F311 FHC ensures our residents are given the appropriate treatment and services to maintain or improve his or her abilities. R5's communication status was reassessed on 2-24-2012 P/O received for SLP to re-eval and treat prn. Care plan was reviewed and revised to reflect the resident's communication status. Random audits of newly admitted residents with communication Problems and current residents will be completed 3x a week by Assistant Administrator, DON /designee and Social Services with Results brought to the QA committee for further follow up and Recommendations. Completion date: 3-5-2012	

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F 311	Continued From page 23 ability to express speech). At 9:15 a.m. on 1/31/12, the social worker (SW-A) was interviewed and stated R5 could answer yes/no questions, and used gestures for communication. At 7:35 a.m. on 2/1/12, R5 was interviewed and asked if the facility had ever tried a communication board. R4 shook her head and said "no. " R5 was asked if she thought a communication board might help her tell staff what she needed, and she nodded her head and said "yes." When asked if she would be willing to try a communication board, R5 nodded her head and said "yes." At 12:11 p.m. on 2/1/12, SW-A stated R5 has a communication board in her room, but refuses to use it. SW-A also stated R5 has refused to work with speech therapy. SW-A stated there was no training regarding communication with R5 provided to new care staff. At 1:25 p.m. on 2/2/12, SW-A took an 8 X 11 inch green laminated page off of R5's nightstand and stated it was R5's communication board. The paper had 17 phrases typed on it. At 3:21 p.m. on 2/2/12, nursing assistant A (NAR-A) was interviewed and stated R5 communicates with gestures, pointing, and one word requests. At 3:24 p.m. on 2/2/12, NAR-D was interviewed and stated communication with R5 can be difficult for new staff, R5 will not allow new staff in the room alone with her, and an experienced staff	F 311		

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F 311	Continued From page 24 has to be with new staff when they go into R5's room. At 3:26 p.m. on 2/2/12, licensed practical nurse E (LPN-E) was interviewed and stated he has had a difficult time understanding R5, and often tells R5 "I don't understand what you need" and this "upsets" her.	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		

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	245258	A. BUILDING _____ B. WING _____	02/03/2012

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

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F 329	Continued From page 25 by: Based on interview and document review the facility failed to adequately assess and monitor clinical indications for ongoing use of medications for 1 of 10 residents (R35) in the sample reviewed for unnecessary medications. Findings include: R35's diagnoses included, ileostomy/ischemic bowel disease, degenerative joint disease, chronic pain syndrome. Fibromyalgia, congestive heart failure, atrial fibrillation, migraine headaches, osteoarthritis and depression. The cardiac status care plan dated 12/1/11, indicated R35 had a history of congestive heart failure and chest pain. The care plan directed staff to give Cardizem CD 300 milligrams (mg) by mouth every 24 hours and hold for a heart rate less than 55 and if R35's systolic blood pressure was less than 100 every day. Physician orders signed 1/16/12. included an order for Cardizem CD 300 mg (heart medication) to be given by mouth every day. The physician's order directed staff to hold the medication if R35's heart rate was less than 55 or the systolic blood pressure was less than 100. The medication administration records (MAR) from 10/1/11 through 2/2/12, lacked documentation of the heart rate and blood pressure (BP) prior to giving the medication. Review of the electronic record indicated a heart rate was documented 13 times in 1/12. No blood pressures were recorded. At 10:38 a.m. on 2/2/12, licensed practical nurse (LPN)-D stated that the pulse and blood pressure were recorded in the electronic medical record	F 329	Revised POC page 26a F329 FHC ensures each resident's drug regimen is free from Unnecessary drugs. R35's BP and pulse is being checked and cardiac medication is being held as ordered by the resident's physician. The results of the checks will be documented in the MAR daily, each time the medication is ordered to be given. Nursing staff were retrained on the facility Policy on checking vital signs and holding cardiac medications according to physician's orders. Nursing staff were also retrained on documenting the results/effectiveness of PRN medication in the MAR after administering the PRN medication. All residents charts were reviewed to ensure that anyone who had an order were in compliance. Random audits of the MARs to check for vital signs checked and documented as ordered and results of PRN medications will be completed by the DON/designee 3XwkX4, then weekly X 4 and monthly thereafter. Audit results will be brought ot the QA Committee for review and any further recommendations. Completion date 3-5-2012	

F329
FHC ensures each resident's drug regimen is free from
Unnecessary drugs.
R35's BP and pulse is being checked and cardiac medication
is being held as ordered by the resident's physician.
The results of the checks will be documented in the MAR
daily, each time the medication is ordered to be given.
Nursing staff were retrained on the facility Policy on
checking vital signs and holding all medications
according to physician's orders. Nursing staff were also
retrained on documenting the results/effectiveness of
PRN medication in the MAR after administering the PRN
medication. All residents charts were reviewed to ensure that

anyone who had an order were in compliance with the physician
request.
All MAR's were audited immediately to check for correct orders
and documentation. Random audits of results of PRN medications
and physician orders will be completed by the DON/designee 3XwkX4,
then weekly X 4 and monthly thereafter.
Audit results will be brought ot the QA Committee for
review and any further recommendations.
Completion date 3-5-2012
F356
Nurse staff posting was revised to ensure information is in a
larger font and the number of hours worked for each type
of Nursing staff is clearly documented. The posting was moved
to a more prominent place that will be readily accessible to
residents and visitors and placed 4-5 feet above the floor so
can be seen easily by residents in wheelchairs.
Audits of required information on the nurse staff posting will
Be completed 3XwkX4, then weeklyX4wks, and monthly
thereafter by the DON/designee.
Audit results will be brought to the QA committee for
review and further recommendations.
Completion date 3-5-2012

Received Time Mar. 1. 2012 11:00AM No. 2191

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F 329	Continued From page 26 (EMR) or on the MAR. At 11:50 a.m. on 2/2/12, registered nurse manager (RNM)-C verified the BP and pulse should be checked before every dose of Cardizem CD for R35. RNM-C verified that only two pulses and no blood pressures were recorded in the EMR. R35's physician orders signed 1/16/12, included Oxycodone HCl (a pain medication) 5 mg by mouth every two hours for break through pain as needed (PRN). Review of the PRN medication administration record indicated R35 had received Oxycodone times in December 2011; however, the results/effectiveness were not recorded seven times. R35 received Oxycodone 12 times in January 2012 and the results/effectiveness were not recorded seven times. At 11:50 a.m. on 2/2/12, RNM-C stated the results/effectiveness of PRN medications should be recorded on PRN MAR or on the progress notes. The facility undated oral medication administration procedure directed staff to obtain and record any vital signs as necessary prior to medication administration. The undated medication administration general guidelines directed staff to document the results achieved with each dose of PRN medication.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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F 356	Continued From page 27 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the nurse staff posting was readily accessible to residents and visitors in a readable format. This had the potential to effect all 40 residents residing in the	F 356	F356 Nurse staff posting was revised to ensure information is in a larger font and the number of hours worked for each type of Nursing staff is clearly documented. The posting was moved to a more prominent place that will be readily accessible to residents and visitors and placed 4-5 feet above the floor so can be seen easily by residents in wheelchairs. Audits of required information on the nurse staff posting will Be completed 3XwkX4, then weeklyX4wks, and monthly thereafter by the DON/designee. Audit results will be brought to the QA committee for review and further recommendations. Completion date 3-5-2012	

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F 356	Continued From page 28 facility. Findings include: The nurse staff posting was observed on 1/30/12 through 2/2/12 to be located behind a transparent panel, in the air lock between two exit doors at the main entry way. The posting was not accessible to residents in wheelchairs. At approximately 12:30 p.m. on 1/30/12 the posting of nursing staff hours was observed to be difficult to interpret and to see. The information was written in script that was 1/16th inch to 1/8th inch tall and the document was approximately 5 feet from the floor. The number of nurses working each shift and the total number of hours each type of nurse worked on each shift was not clear, for example the number of staff was (5=34). There was no explanation to what these numbers meant. At 10:20 a.m. on 2/2/12, the assistant administrator confirmed the posting of nursing hours would not be seen by all residents and confirmed the posting form did not explain what the numbers represented. She further indicated that she thought residents in wheel chairs could see the posting but might not know what the numbers meant. She verified the document was unclear regarding the number of hours and number of nurses that were working each shift.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 29 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure each resident received medications as ordered by the prescriber for 1 of 10 residents (R50) in the sample, reviewed for medication administration. R50 did not receive Ferrous Gluconate 225 mg or tab (used for iron-deficiency anemia) ordered 1/21/12, on discharged from the hospital, for 10 days. R50's diagnoses included anemia. R50's hemoglobin dated 1/23/12 was low at 10.3 (normal range is 13-17g/dL). During a medication pass, observed at	F 425	Revised POC page 30a F425 FHC provides pharmaceutical services to meet the needs of our residents. On 2/1 when LPN called the Pharmacy and the MD, a new order was received for 240mg Ferrous Gluconate. The Pharmacy delivered the medication and it was given to the resident as ordered. An investigation was immediately initiated and a report made to the State Agency on 2/1/12 in regards to the medication not being given per order. Nursing staff were disciplined as appropriate during the investigation. Nursing staff were re-educated on the facility medication administration policy, including the procedure to follow when lacking a medication from the Pharmacy. The Pharmacy consultant was contacted and followed up on the system breakdown. On-coming nursing staff will also be checking the MAR's on their Unit at the beginning of each shift to ensure compliance. Education provided to licensed staff immediately And again on 2-17 to 2-20-12 and 2-27-2012 Audits of Pharmacy delivery process will be conducted by the DON/designee 2XwkX4, then wklyX4wks and monthly thereafter. Audit results will be brought to the QA committee for review and further recommendation. Completion date 3-5-2012	

F425
FHC provides pharmaceutical services to meet the needs
of our residents.
On 2/1 when LPN called the Pharmacy and the MD, a new
order was received for 240mg Ferrous Gluconate. The Pharmacy delivered the
medication and it was given to the resident as ordered.
An investigation was immediately initiated and a report made
to the State Agency on 2/1/12 in regards to the medication not
being given per order.
Nursing staff were disciplined as appropriate during the
investigation. Nursing staff were re-educated on the facility
medication administration Policy, including the procedure to
follow when lacking a medication from the Pharmacy.
The Pharmacy consultant was contacted and followed up on
the system breakdown.
On-coming nursing staff will also be checking the MAR's on their
Unit at the beginning of each shift to ensure compliance.
Education provided to licensed staff immediately
And again on 2-17 to 2-20-12 and 2-27-2012
Audits of Pharmacy delivery process will be
conducted daily x 2 weeks by the DON/designee then
2XwkX4, then wklyX4wks and
monthly thereafter.
Audit results will be brought to the QA committee for review
and further recommendation.
Completion date 3-5-2012

Received Time Mar. 1. 2012 11:00AM No. 2191

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F 425	Continued From page 30 approximately 7:20 a.m. on 2/1/12, R50 did not receive ferrous gluconate as ordered. LPN-A stated there was no supply of ferrous gluconate for R50. LPN-A stated that she would order a supply from the pharmacy. She further indicated that P50 would not receive the ferrous gluconate today but would receive it as normal tomorrow. Review of the R50's medication administration record (MAR), with LPN-A, indicated that R50 had not received ferrous gluconate for the last 10 days of January 2012. LPN-A stated the problem was most likely because the pharmacy did not have that 225 mg dose of that medication, however, she did not know why it had not been followed up on. Interview with the registered nurse manager (NM) -C at 12:20 p.m. on 2/2/12, indicated that R50 missed 10 days of ferrous gluconate because of a communication issue between the facility and the pharmacy. NM-C confirmed that no one followed up when R 50 was not getting the ferrous gluconate as ordered on 1/22/12. She indicated their policy was to call the pharmacy when a medication was not available and to administer it when it comes in from the pharmacy.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	POC page 31a	

F428

The Pharmacy Consultant was contacted on 2-1-2012.
On monthly visits the Pharmacy consultant will be checking medication that have a PO for Pulse and BP to be checked before giving medications and that it is indeed being checked with needed recommendations. The oncoming nursing staff will be checking the MARS's on their unit during their shift to ensure compliance and will alert DON to any missing documentation. A reason code tool and PRN Medication sheet has been revised and placed in each resident MARS to ensure compliance. Education provided to licensed staff immediately on 2-1-2012 and again on 2-17 to 2-20-2012 and 2-27-2012.
All records were immediately audited for compliance and revised if needed.
Audits of all medications with orders for BP and Pulse along with follow up on PRN's will be conducted by the DON/designee 2x wk x4 then wkly x4 and monthly there after.
Results of the Audits will be brought to QA for any further recommendations and follow up
Completion date 3-6-2012

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F 428	Continued From page 31	F 428		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the consultant pharmacist failed to identify and report irregularities in the monitoring of medications for 1 of 10 residents R35 in the sample who were reviewed for unnecessary medications.

Findings included:

R35's diagnoses included ileostomy/ischemic bowel disease, degenerative joint disease, chronic pain syndrome. Fibromyalgia, congestive heart failure, atrial fibrillation, migraine headaches, osteoarthritis and depression.

Physician orders signed 1/16/12, included Cardizem CD 300 mg (heart medication) to be given by mouth every day. The physician's order directed staff to hold the medication if the heart rate was less than 55 or if the systolic blood pressure was less than 100. The medication administration records (MAR) from 10/1/11 through 2/2/12, lacked documentation of the heart rate or blood pressure (BP) prior to giving the medication. Review of the electronic record (EMR) indicated a heart rate was done 13 times in January 2012 and no blood pressures were recorded.

Physician orders signed 1/16/12, included Oxycodone HCl (a pain medication) 5 mg by mouth every two hours for break through pain as needed (PRN).

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F 428	Continued From page 32 The PRN MAR indicated that R35 received Oxycodone times in December 2011, but the results/effectiveness were not recorded seven times. R35 received Oxycodone 12 times in January 2012, but the results/effectiveness were not recorded seven times. The consultant pharmacist reviewed R35's medication regimen monthly and did not make any recommendations regarding the lack of documented pulse/blood pressure for Cardizem or regarding the lack of documented effectiveness or PRN Oxycodone. The consultant pharmacist, interviewed at 3:20 p.m. on 2/2/12, stated they were not aware that the pulse/BP were not documented prior to administration of R35's Cardizem. The pharmacist stated that recording the effectiveness of PRN medications was something the facility had been working on.	F 428	see page 31a F428 The Pharmacy Consultant was contacted on 2-1-2012. On monthly visits the Pharmacy consultant will be checking medication that have a PO for Pulse and BP to be checked before giving medications and that it is indeed being checked with needed recommendations. The oncoming nursing staff will be checking the MARS's on their unit during their shift to ensure compliance and will alert DON to any missing documentation. A reason code tool and PRN Medication sheet has been revised and placed in each resident MARS to ensure compliance. Education provided to licensed staff immediately on 2-1-2012 and again on 2-17 to 2-20-2012 and 2-27-2012. Audits of heart medications with orders for BP and Pulse along with follow up on RPN/'s will be conducted by the DON/designee 2x wk x4 then wkly x4 and monthly there after. Results of the Audits will be brought to QA for any further recommendations and follow up Completion date 3-5-2012	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 33 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide appropriate infection control practices during dressing changes for 1 of 2 residents (R29) in the sample observed for dressing changes. Findings include: R29 was not provided appropriate infection control practices during a dressing change to the right heel. R29's diagnosis included diabetes, morbid obesity and congestive heart failure. The annual	F 441	F441 FHC has an established Infection Control program to help prevent the development and transmission of disease and infection. RN-C was re-educated on the facility policy and procedure on dressing changes on 2-3-2012. All facility Nursing staff were re-educated on the facility policy and procedure on dressing changes on 2-27-2012. Random audits of dressing changes will be completed by DON/ designee 2XwkX4, then wklyX4wks, then monthly thereafter. Audit results will be brought to the QA committee for review and further recommendation. Completion date 3-5-2012	

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F 441	Continued From page 34 Minimum Data Set, dated 11/29/11, indicated R29 had a Stage III pressure ulcer (a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling). The physician orders, signed 12/15/11, directed wound care to be done twice a day with the following: clean with normal saline, nystatin ointment to skin around open area, iodosorb gel, layers of algisite to fill wound base, and protect with ABD pad and kerlix. At 1:13 p.m. on 2/1/12, the dressing change to the right heel was observed with the clinical managers; registered nurses A and C (RN-A and RN-C). RN-C washed her hands, put on gloves, removed the soiled dressing, took off her gloves, and put on clean gloves without washing her hands. RN-C cleansed the pressure ulcer with normal saline, dried it with gauze, then placed iodisorb gel and a layer of algesite onto the pressure ulcer. RN-C completed the dressing change by applying an ABD pad and wrapping the heel in kerlix. At 1:18 p.m. on 2/1/12, RN-C was interviewed and verified she did not wash her hands after removing the soiled dressing, and before putting on clean gloves. When asked if she should have washed her hands after removing the soiled dressing and putting on clean gloves, RN-C stated "definitely." The facility policy and procedure on dressing changes, revised 5/05, directed to remove soiled dressing, discard gloves, wash hands, and put on clean gloves.	F 441		

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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
F 514 SS=F	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and document review, the facility failed to ensure that all medical record entries were closed to prevent alteration at a later date. This practice had the potential to affect all 40 residents in the facility. Specific examples include residents (R5, R22, 29, R50, R43, R35). Findings include: R5's medical record was altered to indicate that communication problems had been addressed. The quarterly care conference summary by the social worker (SW)-A and dated 12/6/11 (not approved) was reviewed and a copy obtained on 2/2/12. The summary lacked any indication that R5's speech or communication problems were addressed. On 2/6/12, the facility sent a fax copy of the same quarterly care conference summary	F 514	F514 The Corporate policy on Electronic Signatures was reviewed and revised by Corporate staff and adopted by the facility. All entries in the EMR will be 'Approved'. If an addition is warranted, a second entry as an addendum or late entry will be made. Staff member was re-educated and disciplined in regards altering/changing medical records. All staff were trained on the revised Electronic Signature Policy on 2-27-2012. Random audits of the entries in the EMR will be conducted 2XwkX4, then weeklyX4 and monthly thereafter to ensure all entries are being 'Approved' in the EMR. Audit results will be brought to the QA committee for Review and further recommendations. Completion date 3-5-2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	02/03/2012

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

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F 514	Continued From page 36 by SW-A. The note was "approved" and still dated 12/6/11; however, the document contained additional information to include, "Resident continues to refuse to use communication board and refuses to work with SLP (Speech Language Pathology) R&B (risks and benefits) completed with resident." The assistant administrator, interviewed at approximately 2:30 pm on 2/2/12, stated that the electronic medical record allows staff to leave an entry open if they are interrupted or called away before the note is complete. The original author can re-enter the note at a later time to finish the documentation and sign off by "approving" the note. EMR entries are not closed until they are "approved." Further record review indicated that R5'sa functional range of motion assessment dated 8/28/11, was not approved. The oral status assessment, the fall risk assessment and a skin risk assessment, all dated 8/29/11, were not approved. All of the assessments remained open to staff revision/alteration of the medical record. R22's medical record contained multiple entries that were not approved and thus subject to potential revision/alteration of the medical record. The comprehensive fall risk assessment was dated 12/19/11 and not approved. The bowel and bladder comprehensive assessment dated 12/20/11 was not approved. The range of motion functional questionnaire dated 12/18/11 was not approved. The oral assessment dated 12/18/11 was not approved. The skin condition assessment dated 12/18/11 was not approved. The progress note regarding a fall on 1/11/12 was not approved. Progress notes on 1/2/12 regarding	F 514		

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F 514	Continued From page 37 a fall on 1/1/12, was not approved. R29's medical record included entries that were left open for potential revision/alteration of the medical record. R29's pain assessment, fall risk assessment and bowel and bladder assessments, all dated 11/29/11, were not approved. Wound rounds notes dated 11/30/11 were not approved. R50's medical record included entries that were left open for potential revision/alteration of the medical record. R50's oral health assessment dated 1/25/12 was not approved. The skin assessment, functional range of motion assessment, pain assessment and bowel and bladder assessments, all dated 1/27/12, were not approved. R43's fall risk assessment dated 5/23/11 was not approved. R35's functional range of motion assessment dated 1/3/12 was not approved. Progress notes dated 11/29/11 were not approved	F 514		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, March 02, 2012 2:40 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Juntunen, Jeffrey (DPS); 'ddegrio@viewcrest.sfhs.org'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Franciscan Health Center (245258) K55 Annual Waiver Request

This is to inform you that Franciscan Health Center is requesting an annual waiver for K55, resident room windows that face an atrium space. The exit date was 2-3-12.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division, Est. 1905
Office: 651-201-7205, Cell: 651-470-4416
FAX: 651-215-0525
Web: fire.state.mn.us

Franciscan Health Center

CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

SION NUMBER(S)	JUSTIFICATION
K-055	An annual waiver is requested for K55 for the following reasons: A. There is not adverse effect of the health and safety of the facility's resident's and staff since the completion of the building project. 1. The building has automatic shut down of all ventilation fans upon a detection of smoke or activation of the fire alarm system. 2. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. 3. Resident sleeping areas are equipped with hard-wired single station smoke detectors or heat activated sprinkler systems. 4. The facility is smoke free and sings to that effect are posted in all major entrances. 5. Annual service and maintenance contracts exist to service all the facility's fire protection systems. 6. The building fire alarm system is monitored to provide automatic fire department notification. 7. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. 8. Fire drills are conducted quarterly on each shift. B. A renewal waiver for one year is being requested for the 7 resident rooms that have windows facing an interior courtyard. 1. The affected rooms are located in a fire-resistive, fully sprinkled portion of the building. 2. This condition was approved by the Minnesota Department of Health, prior to construction of the Atrium spaces. 3. The fire and safety of the residents is not negatively affected by this condition.

RECEIVED
FEB 29 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

or (Signature)	Title	Office	Date
thority Official (Signature)	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 3-2-12

JS-2786R (3/05) Previous Versions Obsolete EF 11/2005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

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

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K 000	INITIAL COMMENTS Building 1 FIRE SAFETY 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. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Franciscan Health Center, Building #1, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19, Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: MR. PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	POC ok FB 3-2-12 RECEIVED FEB 29 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Please see attached waiver	

EXIT: 02.03.2012 DC: 03.15.2012

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

Debra Dahl | Admin | 2-27-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 ST. PAUL, MN 55101-5145 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Franciscan Health Center Building #1 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. Because the original building and the addition meet the construction type for existing buildings, this building was surveyed to Chapter 19, existing health care.. 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. This building does include 7 resident sleeping rooms whose outside windows were enclosed by the construction of a 2006 addtion (Building #2), thus creating a K55 deficiency for the lack of	K 000		

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K 000	Continued From page 2 outside windows. The windows for these rooms do look into a courtyard that is approximately 20 feet high at it's peak. The facility has a licensed capacity of 44 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 055 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door, except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 This STANDARD is not met as evidenced by: Based on observation, an addition was constructed to the front of the building in 2006. The addition created a condition such that some resident rooms no longer have an outside window. This deficient practice could affect all occupants including residents, staff and visitors. Findings Include: During the facility tour between on 1-31-12 between approximately 9:00-11:00AM, it was observed that 8 of 10 resident rooms do not have a window to the exterior, on the street side, this is because of the building addition. The windows now face into an enclosed courtyard. This deficient practice was confirmed by the administrator at the time of exit.	K 055	See attached annual Waive request	

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K 055	Continued From page 3 * Waiver Recommended *	K 055		

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	245258	A. BUILDING 02 - FRANCISCAN HEATLH CEN B. WING _____	01/31/2012

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K 000	INITIAL COMMENTS Surveyor: 03005 THIS INSPECTION ONLY COVERS THE 2006 ADDITION TO FRANCISCAN HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Franciscan Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. The 2006 addition to the Franciscan Health Center is a one (1) story building with no basement. The construction type is determined to be Type II(111). The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 44 beds. All beds in the "new" building were in use at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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