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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3WH1

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 **5/3/2018** (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 ICF/IID	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 **47** (L18)
13.Total Certified Beds **47** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 5/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 5/10/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245258

May 11, 2018

Ms. Brittany Loosbrock, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Dear Ms. Loosbrock:

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 April 23, 2018 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 11, 2018

Ms. Brittany Loosbrock, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: Project Numbers S5258027, H5258022

Dear Ms. Loosbrock:

On February 22, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

On February 22, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F760. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on February 14, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 15, 2018, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby significant corrections are required.

As a result of the survey findings that your facility is not in substantial compliance, the following Category 1 enforcement remedy of State Monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Civil money penalty for the deficiency cited at F760, be imposed. (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective May 5, 2018. (42 CFR 488.417 (b))

On March 28, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed an on-site Post Certification Revisit (PCR) and on May 3, 2018 the Minnesota Department of Health completed

completed 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 an abbreviated standard survey completed on February 14, 2018 and the standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 23, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the surveys, completed on February 14, 2018 and March 15, 2018, as of April 23, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 23, 2018.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the imposed remedies outlined in our letters.

- Civil money penalty for the deficiency cited at F760, be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective May 5, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

In our letter of April 27, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 11, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 5, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 3WH1

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 **03/15/2018** (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 ICF/IID	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 **47** (L18)
13.Total Certified Beds **47** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(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):

17. SURVEYOR SIGNATURE Date :
Kathie Siemsen, HFE NE-II 04/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 04/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :
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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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Amended Letter - Replaces Letter Dated March 30, 2018

Electronically delivered

April 27, 2018

Ms. Brittany Loosbrock, Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: Project Numbers S5258027, H5258022

Dear Ms. Loosbrock:

On February 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

In addition, on February 22, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F-760, (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on February 14, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 15, 2018, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

As a result of the survey findings that your facility is not in substantial compliance, the following Category 1 enforcement remedies will remain in effect:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

- Civil money penalty for the deficiency cited at F-760. (42 CFR 488.430 through 488.444)

In addition, The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and has authorized this Department to notify you of the imposition of this remedy:

- Discretionary Denial of Payment for new Medicare and Medicaid admissions effective May 5, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 5, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2018.

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Franciscan Health Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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), and emergency preparedness deficiencies (these preceded by an "E" tag), i.e. the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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 ePoC 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronically 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	03/15/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/12-3/15/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/12/18, through 3/15/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		4/23/18

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

Electronically Signed | 04/06/2018

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 _____	03/15/2018

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 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a urinary drainage bag was covered to ensure dignity for 1 of 1 residents (R33) reviewed for dignity. Findings include:	F 550	F550 Resident Rights/Exercise of Rights On 3/14/18 R33 Catheter bag was covered to ensure a right to a dignified existence when in bed and up in wheelchair.	

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	245258	A. BUILDING _____ B. WING _____	03/15/2018

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F 550	Continued From page 2 R33's Face Sheet printed 3/15/18, indicated diagnoses that included ataxia (a neurological sign consisting of lack of voluntary coordination of muscle movements that includes gait abnormality), and multi-system degeneration of the autonomic nervous system. R33's significant change Minimum Data Set (MDS) dated 2/21/18, indicated R33 was cognitively intact, and required extensive assistance toileting. The MDS further indicated R33 had an indwelling urinary catheter. On 3/13/18, at 8:30 a.m. R33 was observed from outside of the room, in bed with the uncovered urinary drainage bag hanging on the outside of the bed. The drainage bag contained urine. On 3/13/18, at 11:07 a.m. R33 was observed up in the wheelchair in the main dining room eating brunch. The uncovered urinary drainage bag was hanging under the wheelchair, and was visible. The drainage bag contained urine. On 3/13/18, at 12:45 p.m. R33 was observed from outside of the room, in bed. The uncovered urinary drainage bag was attached under the bed, and visible. The drainage bag contained urine. On 3/13/18, at 12:59 p.m. R33 stated it really didn't bother her that her urinary drainage bag was exposed, but it would be nice if it was covered. On 3/14/18, at 10:30 a.m. R33 was observed being transported in the wheelchair from her room to the main dining room in the wheelchair for brunch. The main dining room was filled with	F 550	R33 Care plan and care sheet was assessed and updated for accuracy by Nurse Manager on 3/15/18. NA-C and NA-D were re-educated by Nurse Manager on ensuring catheter bags are covered when in bed and in wheelchair, on 4/4/18. All residents with catheters have the potential to be impacted by this practice. Nurse Managers to review all residing residents with catheters to ensure they have proper coverage of catheter bag for dignity by 4/23/18. All residents with catheters will have their care plans and care sheets reviewed for accuracy by the Nurse Managers and updated to reflect covering of catheter bag when in bed and up in wheelchair by 4/23/18. The Catheter Care policy was reviewed and revised by the DON and IDT. DON and/or designee will re-educate all staff regarding the Catheter Care policy by 4/23/18. DON and/or designee will audit to ensure proper coverage of catheter bags for dignity. Audits will be completed 3x a week x4 weeks, then 2x a week x2 weeks, and monthly thereafter beginning 4/9/18. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date: 4/23/2018	

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F 550	Continued From page 3 several residents and two residents had visitors of adults and children. The uncovered urinary drainage bag was exposed under the wheelchair, and the urine-filled tubing remained looped out from the lower left side of the wheelchair. On 3/14/18, at 1:28 p.m. the director of nursing (DON) was interviewed and verified R33's urinary drainage bag was uncovered. The DON stated she would expect it to be covered. On 3/15/18, at 9:00 a.m. nursing assistant (NA)-C was interviewed and verified the urinary drainage bag was uncovered. On 3/15/18, at 9:28 a.m. NA-C and NA-D were interviewed. Both NA-C and NA-D stated R33's urinary drainage bag was always kept uncovered. The facility's Catheter Care Policy undated, directed staff to use a cloth storage bag to cover the drainage bag while the resident is in the wheelchair.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe self administration of medications for 1 of 1 residents (R6) observed to self administer a nebulizer. R6's Face Sheet undated, indicated R6's	F 554	F554 Resident Self-Admin Meds-Clinically Appropriate On 3/14/18 R6 was reassessed for Self -Administration of Medication by the IDT team to ensure medication administration	4/23/18

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F 554	Continued From page 4 diagnoses included macular degeneration and vision loss. R6's quarterly Minimum Data Set (MDS) dated 12/22/18, indicated R6 had moderately impaired cognition, and required staff assistance with activities of daily living (ADLs). R6's care plan dated 9/29/17, indicated R6 was unable to self administer medications (SAM) related to visual deficits. The care plan's approach indicated nursing would administer medications as directed by the physician. The care plan lacked indication that R6 could self administer the DuoNeb. The Physician's Order Sheet indicated the physician ordered Ipratropium-Albuterol (DuoNeb, an inhaled medication used in the management of chronic obstructive pulmonary disease and asthma) solution for nebulization (a device used to administer medication in the form of a mist inhaled into the lungs) for shortness of breath, dyspnea (difficulty breathing), and cough on 12/28/17. The order lacked indication that R6 could self administer the DuoNeb. The electronic Medication Administration Record (eMAR) report for March 2018, indicated R6 was to receive the DuoNeb four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. for shortness of breath, dyspnea, and cough. The eMAR directed staff to document lung sounds before and after the nebulizer treatment, to document the response to the nebulizer treatment, and the number of minutes the nebulizer treatment took. The eMAR also directed staff to check the pulse, respirations and oxygen saturation level after the treatment. The eMAR	F 554	safety, resulting in resident remains not appropriate to self-administer nebulizer treatment. R6 Electronic Medical Record and Care plan was reviewed on 3/14/18 by Nurse Manager with no changes necessary. RN-E and LPN-A were re-educated by the Nurse Manager on 3/15/18 on ensuring only residents assessed to safely self-administer nebulizer treatments are allowed to self-administer. All residents receiving nebulizer treatments have potential to be impacted by this practice. All residents receiving nebulizer treatments will be reviewed and assessed for appropriateness to self-administer nebulizer treatments by the IDT team. Any changes with residents plan of care will be updated in the electronic medical record and care plan as needed by the Nurse Manager. All Licensed Nursing Staff will be re-educated on the Self-Administration of Medication by Residents Policy and how to identify via electronic medical record when a resident can self-administer medications by the DON and/or designee by 4/23/18. DON and/or designee will complete audits to ensure proper Self-Administration of nebulizers. 3 resident medication administration audits will be completed weekly x4 weeks, then 2 resident weekly x2 weeks, and 1 resident monthly thereafter beginning 4/9/18. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date: 4/23/2018.	

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F 554	Continued From page 5	F 554		

lacked indication R6 could self administer the DuoNeb.

A General Nurse's Observation dated 3/4/18, indicated R6 did not wish to SAM at this time. The note further indicated R6 had cognitive and physical limitations that could prevent her from safely SAM, and licensed nursing staff would store and administer all medications per the physician's orders.

On 3/12/18, at 7:03 p.m. R6 was observed in bed with the nebulizer mask over her mouth and nose. The mask was connected to a nebulizer machine that was running. There was not any mist coming from the mask and the medication canister appeared empty. RN-E was passing medications to other residents, and was down the hall in and out of resident rooms. At 7:15 p.m. RN-E entered R6's room, removed the nebulizer mask and turned off the machine.

On 3/12/18, at 7:20 p.m. RN-E was interviewed and stated she had been letting R6 SAM her nebulizer treatment alone since she was admitted.

On 3/13/18, at 1:08 p.m. R6 was in her room, in the recliner with the nebulizer mask over her mouth and nose. The mask was connected to a nebulizer machine that was running. R6 was alone in the room. Licensed practical nurse (LPN)-A was down the hall at the medication cart. At 1:21 p.m. R6 removed the nebulizer mask while the nebulizer machine was still running. R6 stated she did not like the sound of a fan running to her right, because she was unable to see where the noise was coming from. At 1:22 p.m. LPN-A entered R6's room, turned off the

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F 554	Continued From page 6 nebulizer machine, and placed the mask on the bedside table. LPN-A explained to R6 that the noise was the nebulizer machine. On 3/13/18, at 1:36 p.m. LPN-A stated she always left R6 alone with the nebulizer running and this was the first time she saw her take it off. On 3/14/18, at 8:46 a.m. RN-D verified the SAM indicated R6 was unable to SAM her nebulizer treatment, and should not be left alone when receiving the nebulizer treatment. On 3/14/18, at 1:28 p.m. the director of nursing (DON) was interviewed and stated he expect staff to stay with the resident during a nebulizer treatment, if the resident was assessed as unable to SAM. The facility's Self Administration of Medications by Residents policy dated 1/8/18, directed if a resident wished to SAM they would be assessed for their ability to safely SAM. The assessment would be completed and reviewed by the interdisciplinary team. Nursing staff would ensure the eMAR and the care plan reflected the SAM.	F 554		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/23/18

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F 812	Continued From page 7 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to wash hands between handling dirty dishes and clean dishes to minimize the possibility of food borne illness and contamination in the dish room. In addition, the facility failed to maintain the kitchen hood in a sanitary condition. This had the potential to affect 46 of 47 residents who received food from the kitchen. Findings include: On 3/14/18, at 1:29 p.m. cook (C)-A was observed pushing racks of rinsed dirty dishes into the dish machine. C-A waited for the wash and rinse cycle to complete before opening the door on the clean end, and pulling the rack out to air dry. C-A did not wash or sanitize hands between touching the rack of dirty dishes, and pulling the rack of clean dishes out of the machine. C-A then returned to the dirty side of the dish machine and pushed a second rack of dirty dishes into the wash/rinse chamber of the dish machine. Without washing or sanitizing hands, C-A returned to the clean side, picked up a rack of clean plate domes, and touched each plate dome while stacking them in their storage space.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary On 3/14/18 Cook (C)-A Returned the plate domes to the dish area to be rewashed after tray contaminated with employee dirty hands. Dietary Manager re-educated Cook (C) A on proper hand hygiene when going from dirty to clean dishes on 3/15/18. On 3/15/18 Environmental Services Director cleaned the kitchen hood filters to ensure proper sanitary conditions. Environmental Services Director was re-educated on ensuring kitchen hood filter is cleaned monthly on 3/15/18 by Administrator. All residents who receive food from the kitchen have potential to be impacted by this practice. Facility Nutrition and Food Service Hand Washing Policy was reviewed with no revisions necessary. Commercial Kitchen Hood Filters and Fire Extinguisher System policy were reviewed and revised by Administrator. Nutrition and Food Service employees will be re-educated on the Nutrition and Food Service Hand Washing Policy for hand	

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F 812	Continued From page 8 On 3/14/18, at 1:29 p.m. C-A described the process for use of the dish machine that included proper washing or sanitation of hands whenever moving from the dirty side to the clean side of the dish machine. C-A did not recall washing his hands when moving from the dirty side of the dish machine to the clean side when observation was occurring. C-A stated they often have volunteers working in the dish room or two staff working: one on the clean side and the other on the dirty side. On 3/15/18, at 11:15 a.m. the hood over the stove and ovens was observed to have a significant layer of dust adhering to the filters of the hood. The dietary manager (DM) confirmed the filters were dirty and stated the hood was professionally cleaned twice a year, and the Environmental Services Director (ESD) was responsible for cleaning the screens monthly. The DM had no documentation of when the filters were cleaned. On 3/15/18, at 11:53 a.m. ESD stated he cleaned the hood when given a verbal request from the DM or kitchen staff that the hood filters needed to be cleaned. The ESD stated the method of cleaning the filters was to remove them from the hood and send filters through the dish machine. The ESD stated he does filter cleaning monthly, not on a set day but when he gets around to it. The ESD said it was usually done on a Friday before the dish machine would be emptied and cleaned by kitchen staff. The ESD stated the hood had been professionally inspected and cleaned in January 2018, so he wouldn't have cleaned the hood until February, as he doesn't clean the filters the month the hood is professionally cleaned. The ESD could not confirm when the filters had last been cleaned,	F 812	hygiene with dirty to clean procedure and following policy by the Dietary Manager by 4/23/18. The Commercial Kitchen and Cooking Equipment Maintenance Policy was updated to include guidance on facility cleaning of filters between professional cleanings. Environmental Service Director was re-educated on the policy and will be completing filter cleaning monthly starting week of 4/9/18. Dietary Manager will complete audits to ensure hand washing is completed when handling dirty to clean dishes per policy. Audits will be completed 3x a week x4 weeks, then 2x a week x2 weeks, monthly thereafter beginning 4/9/18. Audits will be performed monthly on the Kitchen Hood Filter to ensure cleanliness of filter by the Administrator beginning on 4/9/18. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date: 4/23/2018.	

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F 812	Continued From page 9 other than professionally. The completed Kitchen Exhaust Cleaning After Service Follow-Up Report dated 1/25/18, from the contracted vendor indicated the exhaust hood filters were cleaned 1/25/18. Documentation of filter cleaning performed by the ESD was requested but not received from the facility. The facility's Hand Washing of Employees Policy undated, directed hands are to be washed when going from dirty to clean dishes. The facility's Commercial Kitchen Cooking Equipment Maintenance Policy reviewed 7/10/17, directed the kitchen hood be inspected and cleaned by a contracted vendor at least every 6 months. The policy gave no guidance on facility cleaning of filters between professional cleanings.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/23/18

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F 880	Continued From page 10 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 11 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a urinary drainage bag was kept off the floor to prevent the risk of infection for 1 of 1 residents (R33) reviewed for urinary catheter. In addition, the facility failed to ensure proper hand hygiene was maintained during personal cares for 1 of 2 residents (R38) observed during personal cares. Findings include: R33's Face Sheet printed 3/15/18, indicated R33's diagnoses included ataxia (a neurological sign consisting of lack of voluntary coordination of muscle movements that includes gait abnormality) and multi-system degeneration of the autonomic nervous system. R33's significant change Minimum Data Set (MDS) dated 2/21/18, indicated R33 was cognitively intact, and had an indwelling urinary catheter. R33's care plan dated 2/28/18, indicated R33 was at risk for complications such as an urinary tract infection (UTI) related to the indwelling catheter	F 880	F880 Infection prevention and Control On 3/14/18 R33 Urinary drainage bag was repositioned off the floor and covered. NA-A was re-educated on changing of gloves and hand hygiene during provision of care on 3/14/18 by Nurse Manager. On 3/14/2018 R38 room was cleaned and disinfected by housekeeping staff immediately following awareness of this practice. R38 suffered no ill effects from this break in infection control. All residents with catheters have the potential to be impacted by this practice. DON and/or designee will assess all residents Urinary Drainage bag placement to ensure they are positioned off of the floor. Nurse Managers will assess all residents with catheters care plans and care sheets to ensure intervention in place to keep catheter bag off of the floor. The Catheter Care policy was reviewed by IDT and all staff will be re- educated regarding Catheter Care policy by 4/23/18 by DON and/or designee. Audits will be performed to ensure proper	

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F 880	Continued From page 12 use. On 3/13/18, at 12:45 p.m. R33 was observed from outside of the room back in bed. The uncovered urinary drainage bag was attached under the bed, and the bottom of the urinary drainage bag with the drain port was resting directly on the floor. On 3/14/18, at 12:58 p.m. R33 was observed in bed, the uncovered urinary drainage bag was attached to the outer bed rail. The drainage port was directly touching the floor. On 3/14/18, at 1:28 p.m. the director of nursing (DON) was interviewed and referred to registered nurse (RN)-A, the infection preventionist. On 3/15/18, at 9:00 a.m. nursing assistant (NA)-C was observed providing morning cares for R33. NA-C verified the urinary drainage bag was uncovered, and the splashguard portion was laying on the floor. On 3/15/18, at 9:28 a.m. NA-C and NA-D were interviewed and both stated drainage port was usually resting on the floor. On 3/15/18, at 9:41 a.m. RN-A stated the splash guard came with and was part of the catheter drainage system. RN-A stated it was not their process to have catheter bags touching the floor. RN-A further stated the facility's urinary drainage bags had a clamp on the drainage tube, and if it touched the floor bacteria could travel up into the urinary drainage bag. RN-A stated R33's urinary catheter was inserted on 1/26/18, and R33 was diagnosed with a UTI on 2/28/18.	F 880	placement of Urinary Drainage bags off of floor to help prevent the development and transmission of communicable diseases and infections. Audits will be completed 3x a week x4 weeks, then 2x a week x2 weeks, and monthly thereafter beginning on 4/9/18 by DON and/or designee. Hand Hygiene policy was reviewed and all nursing staff will be re-educated by the IPCO Nurse on the policy and proper hand hygiene during Perineal Care by 4/23/18. Perineal Care competency will be completed with NA-A on 4/9/18 date and demonstrated competency. Audits will be performed by the IPCO nurse and/or designee to ensure proper Hand Hygiene during Perineal care. Audits will be completed 5x a week x2 weeks, then 4x a week x2 weeks 3x a week x 2 weeks, then 2x a week x 2 weeks, and 1x a week x 2 weeks, then monthly beginning on 4/9/18. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date: 4/23/2018.	

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 _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13 The facility was unable to provide a policy on urinary catheters. R38's Face Sheet printed 3/15/18, indicated diagnosis of rheumatoid arthritis, and Parkinson's disease. R38's care plan dated 9/26/14, indicated R38 was incontinent, and required extensive assistance from staff with personal hygiene. On 3/14/18, at 8:16 a.m. nursing assistant (NA)-A was observed to provide incontinent cares to R38. NA-A cleansed R38's peri area, and when done, set the soiled washcloth into a plastic bag on the bed. NA-A did not change her soiled gloves or perform hand hygiene. Someone knocked on the door, and NA-A touched the privacy curtain as she went to answer. NA-B came into the room, donned gloves and helped NA-A finish R38's cares. NA-A stated to NA-B that they would wash R38's bottom area when they sat her up in bed. NA-A reached into her pocket, and looked at the care group sheet, NA-A returned the paper to her pocket, then opened R38's drawer for a clean incontinent brief. With soiled gloves, NA-A proceeded to dress R38, transfer R38 with the assistance of NA-B onto commode, and gave R38 the bathroom call light. NA-A removed her soiled gloves. On 3/14/18 2:47 p.m. NA-A stated she knew she was supposed to remove her gloves when they were soiled. On 3/15/18 at 8:55 a.m. director of nursing (DON) stated it would be expected staff removes	F 880		

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F 880	Continued From page 14 soiled gloves and performs hand hygiene following incontinent cares. The facility's policy Hand Hygiene revised on 5/8/17, failed to directed staff on when to remove gloves during provision of care.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		4/23/18

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F 883	Continued From page 15 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure influenza and pneumococcal (pneumonia) vaccines were offered upon admission to 1 of 5 residents (R16) reviewed for immunizations. Findings include: R16's Face Sheet printed 3/15/18, indicated R16 was admitted to the facility on 12/8/17, and was over the age of 65. R16's diagnoses included unspecified bacterial pneumonia, and chronic obstructive pulmonary disease (lung disease characterized by chronic obstruction of lung	F 883	F883 Influenza and Pneumococcal Immunizations On 3/13/18 R16 was assessed for Immunization administration and discussed administration with R16 POA by Nurse Manager. POA did not want R16 to receive immunizations and R16 medical record was updated reflecting this information. All residents admitted after 10/27/17, when Infection Control nurse last audited all residents for immunization administration, have the potential to be	

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F 883	Continued From page 16 airflow that interferes with normal breathing and is not fully reversible). R16's medical record lacked documentation of offering or receipt of immunizations upon admission. On 3/13/18, at 1:53 p.m. registered nurse (RN)-A stated R16 had never received immunizations in R16's life, and had always refused, so an immunization record was not available. RN-A stated immunizations are reviewed on admission by the nurse manager. RN-A stated education and information regarding the influenza and pneumococcal vaccines are provided to residents, but RN-A was not sure if consent or declination forms were done for R16. On 3/15/18, at 11:39 a.m. RN-A verified R16's immunizations were not addressed upon admission. RN-A verified R16's immunizations should have been reviewed and offered on admission. The facility's policy Resident Immunizations revised 6/17, directed all residents would be offered vaccinations based on the Centers for Disease Control (CDC) recommendations and physician orders. The policy directed an immunization history would be taken upon admission, appropriate physician orders obtained, vaccine information would be provided to the residents or responsible party and education provided, which would be documented in the resident's medical record. The resident's or responsible party's decision regarding receipt of the vaccine would be documented in the medical record.	F 883	impacted by this practice. DON and/or designee will complete chart reviews to ensure all residents admitted after 10/27/2017 were offered immunizations upon admission and documented in residents medical records by 4/23/18. Licensed Nurse Supervisory staff will be re-educated by DON on Residents Immunization policy and process for immunization assessment and documentation with all new admissions by 4/23/18. Audits will be performed by DON and/or designee to ensure proper compliance with immunization administration upon admission. Audits will be completed with all new admissions over the next 3 months beginning the week of 4/9/18. Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date: 4/23/2018.	

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	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 22, 2018. At the time of this survey, Franciscan Health Center, was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as 1 building: Franciscan Health Center Building 01 is a 2 story building with a small partial basement. The 2nd level is all office space with no resident access The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(000) construction. In 1970 an addition was constructed that was determined to also be of Type II(00) construction. In 2006 a one story without basement addition was constructed that was determined to be of Type II(000). 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. The facility has a licensed capacity of 47 beds and had a census of 47 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is	K 000		

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

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

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