DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY				ID: 3ZBK			
	PART	I - TO BE COM	PLETED BY TH	HE STAT	E SURVEY AGENCY	Fa	cility ID: 00865
MEDICARE/MEDICAID PROVIDER N (L1) 245258 2.STATE VENDOR OR MEDICAID NO.	0.	3. NAME AND ADD (L3) FRANCISCA (L4) 3910 MINNE	N HEALTH CEN			4. TYPE OF ACTION: 1. Initial	<u>7 (</u> L8) 2. Recertification
(L2) 551218200		(L5) DULUTH, M			(L6) 55802	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUF 01 Hospital		09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Com	9. Other pplaint
6. DATE OF SURVEY 04/13		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING D	DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	06/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		X A. In Complian	ce With		And/Or Approved Waivers Of The	e Following Requirements:	
To (b) :		Program Re			2. Technical Personnel	6. Scope of Service	
12.Total Facility Beds	44 (L18)	Compliance	cceptable POC		 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code 	7. Medical Director 8. Patient Room Siz 9. Beds/Room	
13.Total Certified Beds	44 (L17)		bliance with Program nts and/or Applied W	/aivers:	* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
44							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE	XS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY AP	PROVAL	Date:
17. SORVETOR SIGNATORE		Date .					
Chris Campbell, Unit	-		04/14/2015	(L19)	Mark Meath		04/14/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	LOFFICE OR SINGLE STAT	'E AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Part	7						
2. Facility is not Eligible	ticipate	RIGE	PLIANCE WITH CI ITS ACT:	VIL		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-	1513)
2. Facility is not Englote	ticipate (L21)	RIGE		VIL	2. Ownership/Control I		1513)
22. ORIGINAL DATE	-				2. Ownership/Control I	interest Disclosure Stmt (HCFA-	1513) 30)
	(L21)	ENT 2	ITS ACT:	NT	 Ownership/Control I Both of the Above : 	Interest Disclosure Stmt (HCFA-	30)
22. ORIGINAL DATE	(L21) 23. LTC AGREEM	ENT 2	ITS ACT: 4. LTC AGREEME	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	Interest Disclosure Stmt (HCFA- 	30)
22. ORIGINAL DATE OF PARTICIPATION	(L21) 23. LTC AGREEM	ENT 2	ITS ACT: 4. LTC AGREEME	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	Interest Disclosure Stmt (HCFA- 	30) . <u>RY</u> et Health/Safety
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983	(L21) 23. LTC AGREEM BEGINNING	ENT 2 DATE	ITS ACT: 4. LTC AGREEME ENDING DATE	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u>	30) <u>IRY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24)	(L21) 23. LTC AGREEM BEGINNING (L41)	ENT 2 DATE E SANCTIONS	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25)	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider S	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIVI	ENT 2 DATE E SANCTIONS of Admissions:	ITS ACT: 4. LTC AGREEME ENDING DATE	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u>	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24) 25. LTC EXTENSION DATE:	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIVI A. Suspension (ENT 2 DATE E SANCTIONS of Admissions:	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25)	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider S	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24) 25. LTC EXTENSION DATE:	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension of B. Rescind Sus	ENT 2 DATE E SANCTIONS of Admissions:	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider S	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24) 25. LTC EXTENSION DATE: (L27)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension of B. Rescind Sus	ENT 2 DATE E SANCTIONS of Admissions: pension Date:	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider S	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24) 25. LTC EXTENSION DATE: (L27)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension of B. Rescind Sus	ENT 2 DATE E SANCTIONS of Admissions: pension Date: . INTERMEDIARY/C	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider S	30) . <u>RY</u> et Health/Safety et Agreement
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24) 25. LTC EXTENSION DATE: (L27)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus 29 (L28)	ENT 2 DATE E SANCTIONS of Admissions: pension Date: . INTERMEDIARY/C	ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45) ARRIER NO.	NT (L31)	2. Ownership/Control I 3. Both of the Above : 26. TERMINATION ACTION: <u>VOLUNTARY 00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	Interest Disclosure Stmt (HCFA- (L: <u>INVOLUNTA</u> 05-Fail to Mee nt 06-Fail to Mee <u>OTHER</u> 07-Provider Si 00-Active	30) . <u>RY</u> et Health/Safety et Agreement



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245258

April 14, 2015

Ms. Deborah Degrio, Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

Dear Ms. Degrio:

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 7, 2015 the above facility is certified 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

-Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

April 14, 2015

Ms. Deborah Degrio, Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: Project Number S5258024

Dear Ms. Degrio:

On March 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On April 13, 2015, 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 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2015, effective April 7, 2015 and therefore remedies outlined in our letter to you dated March 12, 2015, 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 related to this letter.

Sincerely,

-Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

lde	ovider / Supplier / CLIA / entification Number 5258	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/13/2015
Name of Fa	Facility		Street Address, City, State, Zip Code	
FRANC	CISCAN 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	i) Date	(Y4) Item	(Y5)	Date (Y4) Item	(۲:	5) D	ate
		Correction Completed			Correction Completed				Correction Completed
ID Prefix	F0241	_04/07/2015	ID Prefix	F0278	_04/07/2015	ID Prefix	F0282		04/07/2015
Reg. #	483.15(a)	_		483.20(g) - (j)	_		483.20(k)(3)(ii)		
LSC		_	LSC		-	LSC			
		Correction			Correction				Correction
ID Prefix	E0311	Completed 04/07/2015	ID Prefix	F0315	Completed 04/07/2015	ID Prefix	E0372		Completed 04/07/2015
	483.25(a)(2)	04/07/2015		483.25(d)	04/07/2015		483.35(i)(3)		04/07/2015
LSC	465.25(a)(2)	_		485.25(0)	-	-	403.33(1)(3)		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0431	04/07/2015	ID Prefix		_	ID Prefix			-
Reg. # LSC	483.60(b), (d), (e)	_	Reg. #		_	Reg. #			
		_	LSC		-				
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_			_				
Reg. # LSC		_	Reg. #		-	Reg. #			
					-				
		Correction			Correction				Correction
ID Drofin		Completed	ID Drofin		Completed				Completed
		_			-				-
Reg. # LSC		_	Reg. # LSC		-	Reg. # LSC			
		_			-	<u> </u>			
Reviewed By		-	Date:	Signature of Surve	-	2		ate:	
State Agenc			04/14/20		1392	2		-	3/2015
Reviewed By CMS RO	/ Reviewed	Ву	Date:	Signature of Surve	eyor:			ate:	
Followup to	Survey Completed on:			-		eficiencies. Was CMS-2567) Sent	to the Feellity?		
	2/27/2015							YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY				ID: 3ZBK			
	PART	I - TO BE COM	PLETED BY TI	HE STAT	E SURVEY AGENCY	I	Facility ID: 00865	
1. MEDICARE/MEDICAID PROVIDER (L1) 245258 2.STATE VENDOR OR MEDICAID NO (L2) 551218200		 NAME AND ADI (L3) FRANCISCA (L4) 3910 MINNE (L5) DULUTH, M 	N HEALTH CEN SOTA AVENUE		(L6) 55802	 TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OV (L9)		7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 02/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	27/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 06/30	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 44 (L37) (L38)		X B. Not in Com	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servi 7. Medical Direc	tor	
16. STATE SURVEY AGENCY REMAN	```	Date :	ATION DATE): 04/01/2015	(L19)	18. STATE SURVEY AGENCY AP		Date: 04/20/2015 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RE	, ,	LOFFICE OR SINGLE STAT	TE AGENCY	(120)	
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible			PLIANCE WITH CI ITS ACT:	IVIL		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCF/	A-1513)	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983	23. LTC AGREEMI BEGINNING		4. LTC AGREEMEI ENDING DATE		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	INVOLUNT 05-Fail to M	L30) FARY eet Health/Safety eet Agreement	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	Status Change	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	Έ	Posted 04/21/2015	5 Co.		
	(L32)			(L33)	DETERMINATION APPRO	VAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6627

March 12, 2015

Ms. Deborah Degrio, Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, Minnesota 55802

RE: Project Number S5258024

Dear Ms. Degrio:

On February 27, 2015, 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 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; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Building 11 East Superior Street, Suite #290 Duluth, Minnesota 55802 Email: Chris.campbell@state.mn.us

Phone: (218) 302-6151 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 April 21, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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

Franciscan Health Center March 12, 2015 Page 3

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.

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

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.

Franciscan Health Center March 12, 2015 Page 4

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 27, 2015 (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

Franciscan Health Center March 12, 2015 Page 5 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 27, 2015 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions related to this notice.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure



3910 Minnesota Avenue 🔳 Duluth, Minnesota 55802 🔳 Telephone: (218) 727-8933 Fax: (218) 727-6610

RECEIVED

MAR 2 7 2015

MN Dept of Health Duluth

MN. Department of Health **Christine Campbell** 11 East Superior Street Suite 290 Duluth, Mn 55802

Dear Ms. Campbell,

Attached is our POC for the 2567 issued by MDH. If you have any questions or need for further information please contact me.

Sincerely,

Deborah De Grio

Administrator

		& MEDICAID SERVICES				. 0938-0391 E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			IPLETED
		245258	B. WING	MN Dept of Health	02/	/27/2015
ME OF P	PROVIDER OR SUPPLIER	;		STREET ADDRESS, CIDY LASTATE, ZIP CO	DE	
	CAN HEALTH CENT	FR		3910 MINNESOTA AVENUE		
ANCIO				DULUTH, MN 55802		
X4) ID REFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	FO	00		
	WILL SERVE AS Y COMPLIANCE UP ACCEPTANCE. Y BOTTOM OF THE	AN OF CORRECTION (POC) OUR ALLEGATION OF ON THE DEPARTMENT'S DUR SIGNATURE AT THE FIRST PAGE OF THE WILL BE USED AS F COMPLIANCE.				
F 241 SS=D	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H ACCORDANCE W 483.15(a) DIGNIT	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN /ITH YOUR VERIFICATION. Y AND RESPECT OF		241		
	manner and in an enhances each re	romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.				
	by: Based on observe review, the facility	ENT is not met as evidenced ation, interview and document failed to provide for dignified ties for 2 of 2 residents (R10,				
	Findings include:			loud		
	included anxiety a Data Set (MDS) o a Brief Interview f	indicated diagnoses that and depression. Her Minimum lated 1/15/15, indicated she ha for Mental Status (BIMS) score paired) and was occasionally	d OK	i addendum Sz		

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 ollowing 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.

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	03/12/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		(X3) DAT	E SURVEY IPLETED
		245258	B. WING	i			02/	27/2015
NAME OF F	PROVIDER OR SUPPLIER	L		STRE	ET ADDRESS, CITY, STATE, ZIP COL	DE	02/	
FRANCIS	SCAN HEALTH CENT	ER			MINNESOTA AVENUE UTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 241	_Continued_From pa		F_	241				
	indicated that she r with toileting or bec	at night. R10's care plan equired one person to assist I pan upon request. Staff was first and last rounds at night.						
	stated sometimes t further revealed sta I'm a nuisance, I do cried when they we	p.m. during interview R10 he staff was crabby. R10 aff had so much to do, "Maybe on't know." R10 stated she ere crabby to her. R10 stated hing because staff will say she e.						4 7
	a.m. and repeated crabby. She contin her cry. R10 stated cried." R10 stated them anymore, but nurse. R10 continu "I talk a lot." R10 fu "wake them" at nig bladder. R10 stated	ed again on 2/25/15 at 8:27 her statement that staff was ued to state one "gal" made d, "I just turned my head and I she didn't want to bother it's their job to be the night ued, saying "they're tired" and orther explained she hated to ht, but she can't control her ed they gave her a bed pan, e, but they're in a hurry.						
•	4:33 a.m. through a although staff ente offered toileting set Director (AD)-A en newspaper and tur stated that she wat AD-A stated the sta bring R10's breakfa the room to get breakfast tray at 7: 7:42 a.m. R10 stat wet but not cold. A	ation of R10' on 2/26/15 from 3:20 a.m. revealed that red the room, no staff asked or rvices. At 7:27 a.m., Activity tered R10's room with the daily ned off the call light. R10 nted to get up for the day. aff were busy but she could ast. R10 agreed and AD-A left eakfast. AD-A returned with a 34 a.m. When interviewed at ed her incontinence pad was t 7:47 a.m., LPN-A entered iministered eye drops and a						-

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3ZBK11

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Facility ID: 00865

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If continuation sheet Page 2 of 18

CENTER	S FOR MEDICARE	AND HUMAN SERVICES				OMB NO.	APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUC			E SURVEY PLETED
		245258	B. WING			02/2	27/2015
NAME OF P	ROVIDER OR SUPPLIER	р Р	·		ESS, CITY, STATE, ZIP	CODE	
FRANCIS	CAN HEALTH CENT	ER		3910 MINNES			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	OVIDER'S PLAN OF CO H CORRECTIVE ACTIC REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
F 241	asked about break she was "getting u explained, "they're sometimes the "the she could have he R10 was interview repeated she was so I'm warm." NA- a.m. to inform R10 she informed NA- incontinence pad. and R10 stated "C stated "Boy I've be R10 then informed toileted or checke when toileted, R10 urine soaked with assisting R10 in th bed was felt to be folded the pad and When asked to fe back out, stated if the pillow. R21 stated during a.m., that lately st and dignity. R21 s she wants to. R2 she'll "simply hav "night girl" came i longer go to the b she would have to R21 stated she n	age 2 hent then left the room. When fast in bed, R10 replied that sed to it." She further so late, it's easier." She stated erapy lady" got her ready so r breakfast in the dining room. red again at 8:10 a.m. and wet, but not cold; "I'm in bed, D entered the room at 8:30 b she would get up soon, when D that she had a wet At 8:34 a.m. NA-D returned Dh boy am I wet." R10 also een laying there a long time." d NA-D that she hadn't been d on all night. At 8:41 a.m. D's brief was observed to be a strong odor. While NA-D was he bathroom, the pad on the damp. At 8:56 a.m., NA-D d tucked it under R10's pillow. el if it was wet, NA-D pulled it t was dry and replaced it under g interview on 2/24/15, at 8:37 taff didn't treat her with respect said she doesn't get to bed whe 21 stated staff come in and say e to wait." R21 also identified a in and informed her she could n bathroom at night. R21 told staff o wet the bed then, and she did ow used the bed pan as she uired too much assistance and	n o	-41			
	was "fine" with th						
	2567(02-99) Previous Versi	d 1/6/15, indicated a BIMS score		Facility ID: 0086	85	If continuation sh	eet Page 3 of 1

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		H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 03/12/2015 FORM APPROVED OMB NO. 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245258	B. WING		02/27/2015
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE	
FRANCIS	SCAN HEALTH CEN	TER		3910 MINNESOTA AVENUE DULUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FHC provides dignified to R10 was re-interviewed r NOC shift.	ileting opportunities for all residents egarding use of a bedpan during the
F 241	indicated that she (less than 7 epison was on a toileting identified a patter early a.m. related was at risk of mo- need for assistar immobility and C R21's current ca approaches: *Assist of two wit that provides star requested, and *Offer assistance R21's care plan is her preference night. During interview stated she got a used to that" an night. R21 state use the bathroon During an interv NA-C stated R2 for about two mo- for residents wh as "most are inco- the urge to urina- night and requir used the bed pa- Upon interview director of nursi recent call light times in 7 days.	cognitive impairment). The MDS e was occasionally incontinent odes in a week) of bladder and program. R21's care plan in of urinary incontinence in the to her urge to void and that she re incontinence related to her ince with toileting, her history of VA (cerebral vascular accident). re plan directed the following th a PAL stand (mechanical lift inding assistance) to toilet as e to toilet. acks evidence to support that it e to always use a bed pan at on 2/25/15, at 1:36 p.m., R21 bed pan at night. She said, "I'm d guessed that everyone did at d, "I don't think anyone gets to in at night." we on 2/26/15, at 5:17 a.m., 1 was a two person transfer and onths staff used bed pans at nigh o required a two person transfer, ontinent". NA-C stated R21 had the "about every 20 minutes" at ed two people to transfer, so staff in at night. Discrete that in a audit, R21 used her call light 198 The DON stated that R21 had ind sometime there is just a	t	 The resident was also refor getting up for the continental break SS/Nurse Manager did m POC per her request. R21 was re-interviewed the NOC Shift. The resider regarding what time she plan was revised per her All residents are being in requests and care plans preference by <u>H</u>-<u>H</u> All residents are being in awakening/eating preference damission and preference admission and preference admission and preference documented per their of All newly admitted resider admission and preference admission and preference being met. 1. NAR care she 2. Care plans will be interviewed the NAR care she 2. Care plans will be interviewed admistrato week x 4 wee ongoing 4. Results will be review and for the content of the preview and for the preview and for	nterviewed about their toileting will be changed according to their -15
				All staff have been edu 2015 and 4-2-2015	cated on 2-28-2015 and again on 4-1-
				Completion date: 4	-1-15

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245258	B. WING			27/2015
NAME OF P	ROVIDER OR SUPPLIER	·		TREET ADDRESS, CITY, STATE, ZIP COL	θE	
FRANCIS	CAN HEALTH CENT	ER	1	910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	Continued From pa		F 241			
	behavioral or anxie "wants to be a prin for the last month to night for R21. 483.20(g) - (j) ASS	" and it was actually a ety issue. The DON stated R21 cess". The DON verified that hey were using the bed pan at ESSMENT RDINATION/CERTIFIED	F 278	3		
SS=D		nust accurately reflect the		F278 Accurate N	IDS	
	each assessment participation of her A registered nurse assessment is con Each individual wil assessment must that portion of the Under Medicare a willfully and know false statement in subject to a civil n \$1,000 for each a willfully and know to certify a materi resident assessm penalty of not mo assessment.	e must sign and certify that the npleted. no completes a portion of the sign and certify the accuracy of assessment. and Medicaid, an individual who ingly certifies a material and a resident assessment is noney penalty of not more than ssessment; or an individual who ingly causes another individual al and false statement in a ent is subject to a civil money re than \$5,000 for each	>	FHC aspires to have accurate info R7's Annual DMS was a miscoding 2015 according the MDS Manual All MDS's will be audited by the N that all coding is checked correctl completion date of <u>3-27-1</u> All MDS's will be audited by the N Managers and DON. Random Au per week x 4 then weekly therea back to the QAPI Committee for recommendations. All nursing staff have been educa on 4-1-2015 and 4-2-2015 Completion date: <u>4-7-1</u>	g and was mod MDS Coordinate y in Section L v S MDS Coordinat dits will be cor ifter with the re review and fur ated on 3-18-20	ified on 2-27- or to ensure vith or, Nurse npleted 2x esults brought ther

Facility ID: 0086

If continuation

		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391			
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		TE SURVEY MPLETED		
		245258	B. WING _		02	/27/2015		
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
RANCIS	CAN HEALTH CENT			3910 MINNESOTA AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 278	Continued From pa	age 5	F 27	78				
ati na i	<u> Based</u> on <u>observa</u> review, the facility Data Set (MDS) w	ation, interview and document failed to ensure the Minimum as accurate for 1 of 1 residents dental status/activities of daily	· · · · ·		1			
	Findings include:							
	indicated R7's diag cerebrovascular d secondary Parkins	isease, anemia, hydrocephalus sonism, flaccid hemiplegia of , trigeminal neuralgia and	1					
	had no teeth prese	nt dated 11/15/14, indicated R7 ent in the upper gums and the everal black rough tooth						
		n dated 6/19/14, indicated R7 gments imbedded in the gums.						
	The annual MDS had no dental pro	dated 11/26/14, indicated R7 blems.						
	observed. R7 did present and on th broken and black	:05 a.m. R7's teeth were not have any upper teeth e bottom R7 had three to four teeth with one larger tooth on that was broken and jagged.						
	verified the annua incorrect. RN-B s	25 a.m. registered nurse (RN)-E al MDS dated 11/26/14 was tated the annual MDS should as obvious or likely cavities or eth.						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	03/12/2015 PPROVED 0938-0391	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		245258	B. WING			02/2	7/2015	
	PROVIDER OR SUPPLIER	, ER	STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 278	Continued From pa		F :	278		-		
F 282 SS=D	reviewed and amen MDS coordinator w audits to identify er corrections prior to the information wa 483.20(k)(3)(ii) SE PERSONS/PER C The services provi must be provided b	RVICES BY QUALIFIED	F	282				
	by: Based on observa review, the facility regarding toileting Findings include: R10's face sheet i included anxiety a Data Set (MDS) d a Brief Interview fo of 7 (severely imp incontinent, mostli indicated that she with toileting or be to check her durin On 2/25/15, at ap assistant (NA)-D a accurate reporter	ENT is not met as evidenced ation, interview and document failed to follow the care plan for 1 of 2 residents (R10). ndicated diagnoses that and depression. Her Minimum ated 1/15/15 indicated she had or Mental Status (BIMS) score vaired) and was occasionally y at night. R10's care plan required one person to assist ed pan upon request. Staff was ng first and last rounds at night. proximately 2:30 p.m. nursing stated that R10 was a fairly . NA-D explained R10 was not of time. NA-D then clarified R1						

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		AND HUMAN SERVICES				PRINTED: 03/12/2015 FORM APPROVED
TATEMENT (S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245258	B. WING	.		02/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP COD	E
FRANCIS	CAN HEALTH CENT	ER		3910 MINNES DULUTH. M	SOTA AVENUE N 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		F282 FHC prov of care	vides care and services ac	cording to the resident plan
F 282	been 5 minutes. Sk reporter. Continuous observ 4:33 a.m. through although staff enter or offered toileting director (AD)-A ent newspaper and tur stated that she wa AD-A stated the st bring R10's breakf the room to get bro breakfast tray at 7 7:42 a.m. R10 star wet but not cold. A R10's room and a nutritional suppler was interviewed a she was wet, but n warm." NA-D enter inform R10 she w informed NA-D th pad. At 8:34 a.m.	age 7 ted a half-hour when it's only he was otherwise a reliable ration of R10 on 2/26/15 from 8:20 a.m. revealed that red R10's room, no staff asked services. At 7:27 a.m., activity tered R10's room with the daily rned off the call light. R10 nted to get up for the day. aff were busy but she could fast. R10 agreed and AD-A left eakfast. AD-A returned with a :34 a.m. When interviewed at ted her incontinence pad was at 7:47 a.m., LPN-A entered dministered eye drops and a nent then left the room. R10 gain at 8:10 a.m. and repeated hot cold; "I'm in bed, so I'm ared the room at 8:30 a.m. to ould get up soon,R10 then at she had a wet incontinence NA-D returned and R10 stated " R10 also stated "Boy I've beer		F 282 FHC provides care and set of care F 282 F 282 F 282 FHC provides care and set of care F 282 F 282 FHC provides care and set of care F 282 F 282 FHC was re-interviewed r NOC shift. The resident was also re- for getting up with care p for the continental break Her care plan was revise and awaking/meals. All newly admitted resid preference choice and ca wishes. All current resid preference choice and co wishes. All current resid time preference with changes accordingly All newly admitted resid preference choice and co wishes. All current resid time preference with changes accordingly. 1. NAR care she carry them in		receiving a tray in her room. er preference of toileting I be interviewed for ned according to their I be interviewed for toileting plan of care will be made II be interviewed for uned according to their ill be interviewed for meal o the plan of care will be
	laying there a long	g time." At 8:41 a.m. when ef was observed to be urine		3	 Random audits will b Manager/Administra 	e conducted by DON/Nurse tor 3 x a week x 4 weeks for hift reporting and toileting and
	8:10 a.m., NA-D s work done, specific check/changes. receive report or	ew on 2/26/15, at approximately stated he was unable to get the fically repositioning and NA-D stated he usually didn't his group list from night shift, so state when R10 was last	,		auditing of reporting a weekly thereafter. Re QAPI Committee for re recommendations	e is met will continue with nd toileting preferences esults will be brought to the eview and further
F 311		ATMENT/SERVICES TO		F 311	f have been re- educated 015 and 4-2-2015	on 2-28-2015 and again on
ORM CMS-	2567(02-99) Previous Versio	ons Obsolete Event ID: 3ZBI	<11	Facil Comple	etion Date <u> </u>	

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DEPARTMENT OF HEALTH				FORM	03/12/2015 APPROVED 0938-0391
ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
	245258	B. WING		02/	27/2015
NAME OF PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE,		
FRANCISCAN HEALTH CENT	ER		3910 MINNESOTA AVENUE DULUTH, MN 55802		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
services to mainta specified in parag	AIN ADLS the appropriate treatment and in or improve his or her abilities raph (a)(1) of this section.		311		-
by: Based on intervie facility failed to pro services for ambu Findings include: Review of R53's f admitted on 10/6/ included subdural occurs between th thin layer of tissue the skull]) and ne the nerves resulti	ENT is not met as evidenced w and document review, the ovide restorative nursing lation for 1 of 3 residents (R53) ace sheet indicated he was 14. R53's admission diagnoses I hemorrhage (bleeding that he surface of the brain and the e that separates the brain from uritis (a change in the state of ng in weakness, loss of the				
R53's admission 10/13/14, and qu	nges of sensation). Minimum Data Set (MDS) date arterly MDS dated 1/6/15, ded extensive assistance with h				
notes, revealed t occupational the The notes indica	al and occupational therapy hat R53 received physical and rapy from 10/6/14 to 12/19/14. ted that at the time of therapy equired contact guard assistant nd a walker.	ce			
to restorative nur from therapy. Re	eupational therapy referred R53 rsing at the time of discharge view of R53's restorative nursir	ng			
DRM CMS-2567(02-99) Previous Versi	ons Obsolete Event ID: 3ZI	3K11	Facility ID: 00865	If continuation sh	eet Page 9

Facility ID: 00865

(1) เหตุ กำลางหมายหลุกคุณ (พระสุขุม 1) เป็นสารให้สมสรีมิมส์สังและ (1) ก็ไปที่ได้มากส่ง If continuation sheet Page 9 of 18

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE COMPI	
		245258	B. WING			02/2	7/2015
	ROVIDER OR SUPPLIER	ER			STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I 'IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	program document been scheduled to The physical thera nursing program si ambulation. The pl restorative nursing Walk with walk (CGA) (routinely re to unsteadiness du staff assist. Walk for 100-2 Staff was enco wheelchair brakes wheelchair. Review of R53's d restorative plans w 1/7/15. Review of identified his resto be offered twice a Specifically, R53's indicated: 1/7/15: walking di meeting goal 1/13/15: walking of meeting goal 1/20/15: walking of meeting goal 1/20/15: walking of meeting goal 1/20/15: walking of meeting goal In January R53 re times in 28 to 48 Review of R53's n indicated he also ambulation on 2/2 2/11/15, 2/12/15,	ts indicated the program had begin on 12/22/14. pist specified the restorative hould focus on transfers and hysical therapist directed the g program to include: ker and contact guard assist equired contact with patient due uring transfer) with belt and one 200 feet twice daily. ouraged to cue resident to lock and push up with hands from locumentation revealed the were not implemented until R53's care plan dated 1/5/15, orative plan for walking was to a day 4-7 days per week. s restorative documents stance 100 feet, 5 minutes, distance of 110 feet, 10 minutes distance of 130 feet, 14 minutes eceived ambulation services 3		31-			

ORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00865

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ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED VAME OF PROVIDER OR SUPPLIER 245258 B. WING 02/27/2015 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802 3910 MINNESOTA AVENUE DULUTH, MN 55802 02/27/2015			HAND HUMAN SERVICES				FOR	D: 03/12/2015 MAPPROVED D. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
Summary statement of Deficiencies ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			245258	B. WING	÷		0	2/27/2015
FRANCISCAN HEALTH CENTER DULUTH, MN 55802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC	NAME OF F	ROVIDER OR SUPPLIEF	λ				PCODE	
(X4) ID SOMMATING THE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC	RANCIS	CAN HEALTH CEN	TER					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	PREFIX	(EACH DEFICIEN)	CY MUST BE PRECEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 311 Continued From page 10 In an interview on 2/26/15, at 10:53 a.m., with occupational therapist (OT)-A, physical therapist (PT)-A, and physical therapist assistant (PTA)-A, OT-A indicated when R53 was admitted, he would have good days and bad days. When admitted, R53 and his family hoped he would return home, but he was not consistently safe enough to make that possible. When therapy was ended on 12/18/14, R53 had reached his maximum potential of CGA. During the interview on 2/26/15, at 10:53 a.m., OT-A and PT-A indicated R53's family noticed a decline in walking and balance ablittes in January and requested a reasessement. OT-A and PT-A stated they completed evaluations for R53 on 1/26/15, and identified a "significant decline" in R53's abilities. Review of the physical therapy initial assessment dated 1/26/15, supported the decline, specifically: Transfers - sit to stand: prior level CGA to current level of moderate assistance (routinely requires 50% physical assistance). The spiscial therapy plan of care dated 1/26/15, indicated the family had noticed a decline approximately a week before which resulted in R53's requiring significantly more assistance for the completion of transfers and ambulation. During interview on 2/26/15, at 10:53 a.m., OT-A and PT-A stated since R53 resumed therapy on 1/26/15, his balance score was slowly improving, his leg strength and transfers were improving as well as exhibiting improvements in walking. PT-A	F 311	In an interview on occupational thera (PT)-A, and physi OT-A indicated wi would have good admitted, R53 and return home, but enough to make t ended on 12/19/1 maximum potenti During the intervi OT-A and PT-A in decline in walking and requested a stated they comp 1/26/15, and iden R53's abilities. Review of the ph dated 1/26/15, su Transfers - sit to level of moderate 50% physical as Transfers - stand level of moderate Transfers - stand current level of moderate Transfers - stand current level of moderate Transfers - stand level of moderate Transfers - stand current level of moderate	2/26/15, at 10:53 a.m., with apist (OT)-A, physical therapist cal therapist assistant (PTA)-A, hen R53 was admitted, he days and bad days. When d his family hoped he would he was not consistently safe that possible. When therapy wa 4, R53 had reached his al of CGA. ew on 2/26/15, at 10:53 a.m., ndicated R53's family noticed a g and balance abilities in Janual reassessment. OT-A and PT-A oleted evaluations for R53 on ntified a "significant decline" in ysical therapy initial assessmer upported the decline, specificall stand: prior level CGA to curre e assistance (routinely requires sistance to transfer). d to sit: prior level CGA to curre e assistance. d and pivot: prior level CGA to curre e assistance. d and pivot: prior level CGA to curre plan of care dated 1/26/15, nily had noticed a decline week before which resulted in gnificantly more assistance for of transfers and ambulation.	s ry nt y: nt ent An g, s	311			

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		AND HUMAN SERVICES				FORMA	03/12/2015 APPROVED 0938-0391
ATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		245258	B. WING _			02/2	7/2015
AME OF F	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				39	10 MINNESOTA AVENUE		
RANCIS	CAN HEALTH CENT	ER		D	ULUTH, MN 55802		
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	working on R53's s They intended to g maximum potentia to see if they can g	age 11 d they planned to continue standing balance and transfers. get R53 back to his previous II, and keep him on a bit longer gain greater improvements g to restorative nursing.	F 3	311	· · · · · · · · · · · · · · · · · · ·	- -	
	assistant (NA)-F in restorative aide w. facility had posted meantime, the floo pick up the restora are 4-5 aides worl after completing th recorded the work station. However, beginning to recor- computerized recor- lin an interview on nurse manager, r indicated they we full-time restorative restorative aide p current floor staff aide, the floor nur restorative servic monitoring of the RN-B was respon	2/25/15, at 9:50 a.m., nursing ndicated the availability of a as "variable." NA-F thought the for a full time position. In the or nursing assistants were to ative work. NA-F stated there king during the day. NA-F stated he restorative, aides always in a book at the nurse's in the last week or so they were rd restorative services in the ord. 2/26/2015 at 1:09 p.m., the egistered nurse (RN)-C re in the process of hiring a ve aide. She stated that a osition was in addition to the . When there was no restorative rsing assistants completed the es. When asked about restorative nursing, she stated hsible for the program. n 2/26/15 at approximately 2:00		FH re R 4 2 4 a 4 i 1	B11 HC provides the appropriate treatment and esidents in order to maintain or improve th 53 was in Physical Therapy during the surv- ntil 3-13-2015 restorative ambulation program was initia 015 and placed on the NAR Care sheet and Il restorative ambulation programs were r and placed on the NAR Care sheets by 3-27 NI NAR's were trained on putting the Rest nto the EMR kiosk by 3-25-2015 Random audits of the NAR documentation Program will be conducted by the MDS Co Nurse Managers and Administrator daily x week x2 weeks and weekly thereafter. Aud brought to the QAPI Committee for review recommendations. All staff were educated on 2-28-2015 and a and 4-2-2015 Completion Date $4-7-15$	eir abilitie vey and co ated on 3 d in his ca reviewed, 7-2015. torative m on the re ordinator 2 weeks, dit results r and furth	es. ontinued -15- re plan. revised ninutes estorative , DON, then 2x will be ner
	p.m., registered r restorative nursir therapy recomme for monitoring the 1/5/15. RN-B sta	nurse (RN)-B indicated the ng program was based on endations. RN-B was responsibl e restorative program as of ted the facility had a restorative the process of hiring a	e		Ŷ		
ORM CMS	2567(02-99) Previous Versi	ons Obsolete Event ID: 3ZBI	K11	F	Facility ID: 00865 If continu	ation she	et Page 12

		AND HUMAN SERVICES				FORMA	03/12/2015 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245258	B. WING			02/2	27/2015
	CAN HEALTH CENT	ER	1	39	REET ADDRESS, CITY, STATE, ZIP CODE 10 MINNESOTA AVENUE JLUTH, MN 55802	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315 SS=D	RESTORE BLADD Based on the resid assessment, the faresident who enter indwelling catheter resident's clinical of catheterization was who is incontinent treatment and servinfections and to re- function as possible This REQUIREME by: Based on observa- review, the facility provided for 1 of 2 Findings include: R10's face sheet i included anxiety a Data Set (MDS) da a Brief Interview for of 7 (severely imp incontinent, mostly Assessment dated assistance from o she was occasion night. R10's care of that she required toileting or bed par check her during for R10 was interview and stated she did	ent's comprehensive acility must ensure that a is the facility without an is not catheterized unless the condition demonstrates that is necessary; and a resident of bladder receives appropriate vices to prevent urinary tract estore as much normal bladder le. ENT is not met as evidenced ation, interview and document failed to ensure toileting was		315	F315 FHC ensures toileting is being provide R10 was re-interviewed regarding toil the plan of care was revised according R10 NAR care sheet was revised. Shift report will be conducted at the with prior shift letting oncoming shift were last toileted. Random audits will be conducted by D regarding shift report being conducted NAR Care sheets, 3x week x2, then 2x thereafter. Random audits will be conducted by to Mangers on each resident's toileting p they are being followed, 3x a week x weekly thereafter. Audit results will be brought to the Qu review and further recommendations All staff have been educated on 2-28-2 2015 and 4-2-2015 Completion date: <u>4-7-15</u>	leting prefi gly. beginning when the DON/Nurse d and the o week x2 a the DON/N preference 2, then 2x API Commi	erences and of the shift e residents e Mangers use of the and weekly durse es ensuring week x2 then ittee for
							1 Dawa 40 -641

ORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: 3ZBK11

Facility ID: 00865

EMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			MPLETED
		245258	B. WING		+	02	/27/2015
ME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COD 910 MINNESOTA AVENUE	θE	
ANCIS	CAN HEALTH CENT	ER			ULUTH, MN 55802		
(4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG)	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
- 315	Continued From pa aknowledged need toileting.	age 13 Jing staff assistance with	F	315			
	assistant (NA)-D s accurate reporter. reliable for length would say she wa	proximately 2:30 p.m. nursing tated that R10 was a fairly NA-D explained R10 was not of time. NA-D then clarified R10 ited a half-hour when it's only he was otherwise a reliable)				
	4:33 a.m. through although staff enter offered toileting set director (AD)-A en newspaper and tu stated that she wa AD-A stated the si bring R10's break the room to get br breakfast tray at 7 7:42 a.m. R10 sta wet but not cold. A	vation of R10 on 2/26/15, from 8:20 a.m. revealed that ered the room, no staff asked of ervices. At 7:27 a.m., activity tered R10's room with the daily rned off the call light. R10 anted to get up for the day. taff were busy but she could fast. R10 agreed and AD-A left eakfast. AD-A returned with a ':34 a.m. When interviewed at ted her incontinence pad was At 7:47 a.m., LPN-A entered dministered eye drops and a			· ·		
	nutritional suppler R10 was interview repeated she was so I'm warm." NA a.m. to inform R1 time she informed incontinence pad. and R10 stated "0 stated "Boy I've b R10 then informe toileted or checked	ment then left the room. ved again at 8:10 a.m. and wet, but not cold; "I'm in bed, -D entered the room at 8:30 0 she would get up soon, at tha I NA-D that she had a wet At 8:34 a.m. NA-D returned Dh boy am I wet." R10 also een laying there a long time." d NA-D that she hadn't been ed on all night. At 8:41 a.m. 0's brief was observed to be	ıt				

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		AND HUMAN SERVICES				FORM AF	PROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO, 0</u>	938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	
		245258	B. WING			02/27	/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	ER			10 MINNESOTA AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 372 F 372 SS=C	 483.35(i)(3) DISPO PROPERLY The facility must diproperly. This REQUIREME by: Based on observation failed to ensure prithe outside dumpsters During observation facility's dumpster dumpsters. One was garbage held the of feet. The other du and the cover was dumpsters a bed On 2/25/15, at 12 provided a tour of garbage dumpster 2-3 feet and M-A explained that one the other is for ca that waste manag Monday, Wednes 	DSE GARBAGE & REFUSE ispose of garbage and refuse INT is not met as evidenced ation, and interview the facility oper containment of garbage in	F	372 372			
	overly full and op observed the dun them. During the tour of explained housed bring bagged gar it in the green, wi	en. M-A stated when he npsters open he would close n 2/25/15, at 12:39 p.m., M-A keeping and other staff would bage from the facility and place red, open wagon (referred to by 'cart''). The cart stood next to th					
ORM CMS	-2567(02-99) Previous Versio			F	acility ID: 00865 If contin	uation sheet	Page 15 of 18

				PLE CONSTRUCTION	(¥3) Г	ATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G		OMPLETED
		245258	B. WING			2/27/2015
AME OF F	ROVIDER OR SUPPLIER	· · ·		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
RANCIS	CAN HEALTH CENT	ER		3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	F372 FHC will ensure that garbage w A policy has been developed in	ill be dispose	
F 372	cart was full, main took the cart to the During an interview stated the facility h On 2/26/2015 at 4 dumpster was aga open. In an intervi housekeeper (H)-, garbage to the car housekeepers bro throughout the da and maintenance cart to the dumps day. 483.60(b), (d), (e)	age 15 itchen. M-A stated when the tenance and housekeeping dumpster and emptied it. w on 2/25/15, at 1:06 p.m. M-A had no garbage policy. :33 a.m., the cover of the ain observed to be partially ew on 2/26/15 at 10:09 a.m., A stated night staff brought rt at the end of their shift. The bught garbage out to the cart y. H-A stated housekeeping transported garbage via the ter as needed throughout the DRUG RECORDS, BUGS & BIOLOGICALS		F 372 garbage from the facility and or containers supplied by the garb Waste Management has been a pickup is completed the driver garbage container is closed pro Once the weather is cooperative on the garbage containers to re need to be closed at all times. Staff have been educated that in the green cart outside of the it directly to the garbage conta Audits will be conducted daily Administrator to ensure compl All staff have been educated o 2015 and 4-2-2015 Results of audits will be broug review and further recommen		y. once garbage that the lid of the vill also be placed one that they leave any garbage nstead must take osal. ekeeping and and again on 4-1-
55=E	The facility must e a licensed pharms of records of rece controlled drugs i accurate reconcil records are in orc controlled drugs i reconciled. Drugs and biolog labeled in accord professional prine appropriate acce instructions, and applicable.	employ or obtain the services or acist who establishes a system opt and disposition of all n sufficient detail to enable an iation; and determines that drug der and that an account of all- s maintained and periodically icals used in the facility must be ance with currently accepted ciples, and include the ssory and cautionary the expiration date when ith State and Federal laws, the e all drugs and biologicals in	3	Completion date: <u>4-7-1</u>		

ENTER		AND HUMAN SERVICES				OMB NO	APPROVED . 0938-0391
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		E SURVEY
		245258	B. WING			02	/27/2015
IAME OF F	PROVIDER OR SUPPLIEF	λ			ET ADDRESS, CITY, STATE, ZIP CODE		
RANCIS	CAN HEALTH CEN	TER			UTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
<u>F</u> _431	controls, and perr have access to th The facility must p permanently affix controlled drugs I Comprehensive I Control Act of 19 abuse, except wh package drug dis	ents under proper temperature nit only authorized personnel to e keys. provide separately locked, ed compartments for storage of isted in Schedule II of the Drug Abuse Prevention and 76 and other drugs subject to hen the facility uses single unit tribution systems in which the minimal and a missing dose can		431			
	by: Based on obser review, the facilit	ENT is not met as evidenced vation, interview and document y failed to ensure expired e removed from the medication dication carts.					
	the Lakeside uni bottle of xalatan 12/4/14. License verified xalatan opening.	03 p.m. the medication cart on t was observed to have one eye drops with an open date of ed Practical Nurse (LPN)-B eye drops expire 42 days after					
	the Bayside unit following expire Nitrostat 0.4 mil 5/31/13, and an of Nitrostat 0.3	:10 p.m. the medication cart on was observed to have the d medications: one bottle of ligrams (mg) dispense date of expiration date of 5/14; one bottl mg with a dispense date of 1/1/14 on date of 1/15; one bottle of					

	• •						02/12/2015
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/12/2015 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · · /	SURVEY PLETED
		245258	B. WING			02/2	27/2015
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	CAN HEALTH CENT				10 MINNESOTA AVENUE JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	and an expiration d	th a dispense date of 3/12/12, late of 3/13; and two bottles of	_ F	431			
·	expiration date of 1 verified the expirati			 A mark the second s	F431 Expired meds FHC will ensure all expired medication the med carts.		
	(DON) was intervie carts should be che by the night nursin occasionally the fa	2 p.m. the director of nursing ewed and stated the medication ecked for expired medications g staff. The DON further stated cility pharmacy will check the or expired medications.			Night shift is assigned to check carts weekly. Audits of the med carts will be cond Managers 3x week x2 weeks, then 2 weekly basis there after to ensure a have been removed and discarded.	ucted by the	DON/Nurse
	medications direct discarded 42 days facility policy and p	ce on when to discard s xalatan eye drops to be after opening. The undated procedure on Storage of s the facility should not used ons.			Audit results will be brought to the C review and further recommendation All staff have been re-educated on 2 1-2015 and 4-2-2015 Completion date: <u>4-7-2615</u>	s	
					completion date: <u>4=1=2015</u>		
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4-1-2015

Addendum: F 311

Visual random audits will be completed to ensure staff are ambulating residents per their ambulation program. This will be audited by the DON, Nurse Managers, MDS Coordinator and Administrator daily x2 weeks, and if compliance is met will reduce to 2x week/2 weeks then weekly. Results will be brought to QAPI for further recommendations and review.

Addendum: F315

Visual random audits will be completed to ensure that resident plan of care in regards to toileting preference/needs are being met. This will be completed by

- 1. Random interviews with residents in regards to preference/needs
- 2. Random visual checks

This will be the responsibility of the DON, Nurse Managers and Administrator daily x2 weeks and if compliance is met will continue with auditing 2x week/x2 then weekly. Results will be brought to QAPI for recommendations.

		AND HUMAN SERV & MEDICAID SERVI		F52s	58023	FORM	03/03/2015 APPROVED 0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLI	
		245258		B. WING		02/2	4/2015
	ROVIDER OR SUPPLIER	ITER	3910 MI		STATE, ZIP CODE A AVENUE 802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY		ad by the				
	Minnesota Departm time of this survey, Building #1, was fou with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National F	Survey was conductor ent of Public Safety. Franciscan Health C und in substantial co the for participation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc D1, Life Safety Code g Health Care.	At the center, ompliance 2000 siation				
	building with a small level is all office spa	Center Building #1 is I partial basement. T ace with no resident a onstructed at 2 differe	he 2nd access				
	was determined to I construction. In 197 that was determined construction. Becau the addition meet th	0 an addition was co d to also be of Type I use the original buildi the construction type f his building was surv	onstructed I(00) ng and or				
	entire facility has a calarm system with s	fire sprinkler protect complete addressab moke detection in th s open to the corrido	le fire e				
		rly 2 hour fire separa as constructed in 20					
		ensed capacity of 44 f 41 at the time of th					
1	The requirement at	42 CFR Subpart 483	3.70(a) is	51			
LABORATOF	RY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE	NTATIVE'S SIGN	IATURE	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.

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES ICES			FORM	03/03/2015 APPROVED 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	RVEY TED
		245258		B. WING		02/24	/2015
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
FRANCI	SCAN HEALTH CEN	ITER		IINNESOTA TH, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I INTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
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FORM CMS-2567(02-99) Previous Versions Obsolete

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV		Ŧ5	258023	FORM	: 03/03/2015 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRANCISCAN HEATLH CENTER		(X3) DATE SURVEY COMPLETED		
	245258			B. WING		02/2	24/2015	
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE			
FRANCISCAN HEALTH CENTER 3910 MINNESOTA AVENUE DULUTH, MN 55802								
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS			K 000				
		I ONLY COVERS TH ANCISCAN HEALTH						
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Franciscan Health Center, Building #2, 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 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care.							
	Franciscan Health Center Building #2 is a 2006 addition and is a one (1) story building with no basement. The construction type is determined to be Type II(000). Building # 2 is properly fire separated from building #1.							
	facility has a compl system, with smoke spaces open to the automatic fire depa resident rooms hav detectors that trans entire facility has a census of 39 at the		ler ridors and hitored for All ke htion. The 44 and a					
	The requirement at met.	42 CFR Subpart 48	3.70(a) is					
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	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 Any denciency statement enoung 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.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7013 2250 0001 6356 6627

March 12, 2015

Ms. Deborah Degrio, Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, Minnesota 55802

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5258024

Dear Ms. Degrio:

The above facility was surveyed on February 23, 2015 through February 27, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

March 12, 2015 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Building 11 East Superior Street, Suite #290 Duluth, Minnesota 55802 Email: Chris.campbell@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

Franciscan Health Center

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this notice.

Sincerely,

Mark meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

PRINTED: 03/12/2015 FORM APPROVED

Minneso	ta Department of He	alth									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		00865	B. WING		02/27/2015						
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE								
3910 MINNESOTA AVENUE											
FRANCISCAN HEALTH CENTER 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE						
2 000	Initial Comments		2 000								
	*****ATTE	NTION*****									
	NH LICENSING CORRECTION ORDER										
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.									
	corrected requires requirements of the number and MN R When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was									
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.			5						
Minnesota	surveyors of this D above provider and orders are issued. completed, please these orders and r Minnesota Departr	TS: 4, 25, 26 and 27, 2015, epartment's staff, visited the d the following correction When corrections are sign and date, make a copy of eturn the original to the nent of Health, Division of		Minnesota Department of Health documenting the State Licensing Correction Orders using federal Tag numbers have been assigned Minnesota state statutes/rules for Homes.	software. d to						
Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE											
Seborah MD This administrator 3-27-19											
STATE FOR	RM	i i i i i i i i i i i i i i i i i i i	6899	3ZBK11	If continuation sheet 1 of						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00865	B. WING		02/27/2015	
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RANCIS	CAN HEALTH CENT	FR	INESOTA AV , MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	2 000 Continued From page 1 Compliance Monitoring, Licensing and Certification Program, Christine Campbell, 11 East Superior St., #290, Duluth, MN 55802.			The assigned tag number a far left column entitled "ID The state statute/rule numl corresponding text of the s out of compliance is listed "Summary Statement of De column and replaces the "T portion of the correction or column also includes the are in violation of the state statement, "This Rule is no evidenced by." Following findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD TH THE FOURTH COLUMN V STATES, "PROVIDER'S PI CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH	Prefix Tag." ber and the tate statute/rule in the eficiencies" To Comply" der. This findings which statute after the ot met as the surveyors I Method of eriod For E HEADING OF VHICH LAN OF PLIES TO ONLY. THIS	
				THERE IS NO REQUIREM SUBMIT A PLAN OF CORI VIOLATIONS OF MINNES STATUTES/RULES.	RECTION FOR	
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	This MN Requireme	ent is not met as evidenced				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00865	B. WING		02/	27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FRANCI	SCAN HEALTH CENT	5910 MIN	INESOTA AVEI	NUE		
MANCI	SCAN HEALIN CENT	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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 2	2 565			
	by: Based on observation, interview and document review, the facility failed to follow the care plan regarding toileting for 1 of 2 residents (R10).					
	Findings include:					
	included anxiety an Data Set (MDS) da a Brief Interview for of 7 (severely impa incontinent, mostly indicated that she r with toileting or bed to check her during On 2/25/15, at appr assistant (NA)-D st accurate reporter. reliable for length o would say she waite	dicated diagnoses that d depression. Her Minimum ted 1/15/15 indicated she had Mental Status (BIMS) score ired) and was occasionally at night. R10's care plan equired one person to assist l pan upon request. Staff was first and last rounds at night. roximately 2:30 p.m. nursing ated that R10 was a fairly NA-D explained R10 was not f time. NA-D then clarified R10 ed a half-hour when it's only ne was otherwise a reliable				
	4:33 a.m. through 8 although staff enter or offered toileting s director (AD)-A enter newspaper and turn stated that she war AD-A stated the sta bring R10's breakfa the room to get bre breakfast tray at 7: 7:42 a.m. R10 state wet but not cold. At	ation of R10 on 2/26/15 from 3:20 a.m. revealed that red R10's room, no staff asked services. At 7:27 a.m., activity ered R10's room with the daily ned off the call light. R10 nted to get up for the day. off were busy but she could ast. R10 agreed and AD-A left akfast. AD-A returned with a 34 a.m. When interviewed at ed her incontinence pad was 7:47 a.m., LPN-A entered ministered eye drops and a				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00865	B. WING		02/	27/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVEI MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	was interviewed ag she was wet, but no warm." NA-D entere inform R10 she wor informed NA-D that pad. At 8:34 a.m. N "Oh boy am I wet." laying there a long toileted, R10's brief soaked with a stron During an interview 8:10 a.m., NA-D sta work done, specific check/changes. N/ receive report or his he was unable to st toileted. Suggested Method The director of nurs (s)could review and procedures related each individual resi The director of nurs develop a system to monitoring system	ain at 8:10 a.m. and repeated ot cold; "I'm in bed, so I'm ed the room at 8:30 a.m. to uld get up soon,R10 then she had a wet incontinence IA-D returned and R10 stated R10 also stated "Boy I've been time." At 8:41 a.m. when was observed to be urine go dor. on 2/26/15, at approximately ated he was unable to get the ally repositioning and A-D stated he usually didn't s group list from night shift, so itate when R10 was last of Correction: sing (DON) or designee I revise policies and to ensuring the care plan for	2 565	DEFICIENC	Y)	
2 910	Time Period for Co MN Rule 4658.052 Incontinence	rrection: 21 days 5 Subp. 5 A.B Rehab -	2 910			
	Subp. 5. Incontine have a continuous management to rec	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00865	B. WING		02/	02/27/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE				
RANCIS	SCAN HEALTH CENT	FR	NNESOTA AVEI I, MN 55802	NUE			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 910	Continued From pa	age 4	2 910				
	home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropria prevent urinary trace	sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates to was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.					
	by: Based on observat	tion, interview and document failed to ensure toileting was residents (R10).					
	Findings include:						
	included anxiety ar Data Set (MDS) da a Brief Interview fo of 7 (severely impa- incontinent, mostly Assessment dated assistance from or she was occasiona night. R10's care p that she required or toileting or bed par	ndicated diagnoses that and depression. Her Minimum ated 1/15/15 indicated she had r Mental Status (BIMS) score aired) and was occasionally at night. R10's Care Area 1/29/15, identified she needed he staff member to toilet and ally incontinent, especially at alan dated 1/19/15, indicated one person to assist with a upon request. Staff was to rst and last rounds at night.	ł				
	and stated she did but she couldn't co	ed on 2/25/15, at 8:27 a.m., n't like to bother the night staff ntrol her bladder and ling staff assistance with					

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00865	B. WING		02/	02/27/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
RANCIS	CAN HEALTH CENT	FR	NESOTA AVE	NUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 5	2 910		,		
	toileting.						
	assistant (NA)-D st accurate reporter. reliable for length c would say she wait	roximately 2:30 p.m. nursing tated that R10 was a fairly NA-D explained R10 was not of time. NA-D then clarified R10 ed a half-hour when it's only ne was otherwise a reliable)				
	4:33 a.m. through 8 although staff enter offered toileting ser director (AD)-A ent newspaper and tur stated that she war AD-A stated the sta bring R10's breakfa the room to get bre breakfast tray at 7: 7:42 a.m. R10 state wet but not cold. At R10's room and ad nutritional supplem R10 was interviewe repeated she was so I'm warm." NA-E a.m. to inform R10 time she informed incontinence pad. A and R10 stated "OI stated "Boy I've bee R10 then informed toileted or checked	ation of R10 on 2/26/15, from B:20 a.m. revealed that red the room, no staff asked or rvices. At 7:27 a.m., activity ered R10's room with the daily ned off the call light. R10 nted to get up for the day. aff were busy but she could ast. R10 agreed and AD-A left eakfast. AD-A returned with a 34 a.m. When interviewed at ed her incontinence pad was t 7:47 a.m., LPN-A entered liministered eye drops and a ent then left the room. ed again at 8:10 a.m. and wet, but not cold; "I'm in bed, D entered the room at 8:30 she would get up soon, at that NA-D that she had a wet At 8:34 a.m. NA-D returned h boy am I wet." R10 also en laying there a long time." NA-D that she hadn't been I on all night. At 8:41 a.m. 's brief was observed to be a strong odor.					
		THOD OF CORRECTION:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00865	B. WING		02/	27/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
RANCIS	SCAN HEALTH CENT	FR	NESOTA AVE , MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 6	2 910			
	develop policies an residents receive a determined necess assessment and di The director of nurs educate all appropri procedures. The di	R CORRECTION:				
2 915		5 Subp. 6 A Rehab - ADLs	2 915			
	comprehensive reshome must ensure A. a resident is treatments and ser abilities in activities deterioration is a net the resident's cond part, activities of da resident's ability to (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speec	s given the appropriate vices to maintain or improve s of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the ss, and groom; nd ambulate;				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00865	B. WING		02/	02/27/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
FRANCIS	SCAN HEALTH CENT	FR	INESOTA AVEI , MN 55802	NUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 7	2 915				
	facility failed to prov	r and document review, the vide restorative nursing ation for 1 of 3 residents (R53).					
	Findings include:						
	admitted on 10/6/1 included subdural h occurs between the thin layer of tissue the skull]) and neur	ce sheet indicated he was 4. R53's admission diagnoses nemorrhage (bleeding that e surface of the brain and the that separates the brain from ritis (a change in the state of g in weakness, loss of the les of sensation).					
	10/13/14, and quar	inimum Data Set (MDS) dated terly MDS dated 1/6/15, d extensive assistance with his					
	notes, revealed tha occupational therap The notes indicated	and occupational therapy It R53 received physical and by from 10/6/14 to 12/19/14. I that at the time of therapy juired contact guard assistance I a walker.					
	to restorative nursing from therapy. Review	bational therapy referred R53 ng at the time of discharge ew of R53's restorative nursing is indicated the program had begin on 12/22/14.					
	nursing program sh ambulation. The ph restorative nursing Walk with walk	pist specified the restorative nould focus on transfers and hysical therapist directed the program to include: er and contact guard assist quired contact with patient due					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00865	B. WING		02/2	27/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVE	NUE		
		DULUTH,	MN 55802			-1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	ige 8	2 915			
	 to unsteadiness during transfer) with belt and one staff assist. Walk for 100-200 feet twice daily. Staff was encouraged to cue resident to lock wheelchair brakes and push up with hands from wheelchair. Review of R53's documentation revealed the restorative plans were not implemented until 					
	identified his restor be offered twice a c Specifically, R53's r indicated:	853's care plan dated 1/5/15, ative plan for walking was to day 4-7 days per week. restorative documents ance 100 feet, 5 minutes,				
	1/13/15: walking dis meeting goal 1/20/15: walking dis meeting goal In January R53 rec times in 28 to 48 op Review of R53's res indicated he also re ambulation on 2/3/1 2/11/15, 2/12/15, 2/	stance of 110 feet, 10 minutes, stance of 130 feet, 14 minutes, eived ambulation services 3 oportunities. storative documentation eceived restorative services for 15, 2/4/15, 2/5/15, 2/10/15, 13/15 and 2/24/15. In ulated 8 times in 32 to 54				
	occupational therap (PT)-A, and physica OT-A indicated whe would have good da admitted, R53 and return home, but he enough to make that	2/26/15, at 10:53 a.m., with bist (OT)-A, physical therapist al therapist assistant (PTA)-A, en R53 was admitted, he ays and bad days. When his family hoped he would e was not consistently safe at possible. When therapy was , R53 had reached his of CGA.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00865	B. WING		02/27/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RANCI	SCAN HEALTH CENT	FR	NNESOTA AVE	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	age 9	2 915			
	OT-A and PT-A inc decline in walking a and requested a re stated they complet 1/26/15, and identi R53's abilities. Review of the phys dated 1/26/15, sup Transfers - sit to st level of moderate a 50% physical assis Transfers - stand to level of moderate a Transfers - stand a current level of mo physical therapy pl indicated the family approximately a we R53 requiring signi the completion of t During interview or and PT-A stated si 1/26/15, his balanch his leg strength an- well as exhibiting ir and OT-A indicated working on R53's s They intended to g maximum potentia to see if they can g before discharging In an interview on a assistant (NA)-F in restorative aide wa	o sit: prior level CGA to curren	t t			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00865	B. WING		02/	02/27/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
		3910 MIN	NESOTA AVEI				
FRANCE	SCAN HEALTH CENT	DULUTH	, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 915		-	2 915				
	pick up the restorat are 4-5 aides worki after completing the recorded the work is station. However, in beginning to record computerized record In an interview on 2 nurse manager, reg indicated they were full-time restorative restorative aide pos current floor staff. V aide, the floor nursi restorative services monitoring of the re RN-B was responsi	2/26/2015 at 1:09 p.m., the gistered nurse (RN)-C in the process of hiring a aide. She stated that a sition was in addition to the When there was no restorative ng assistants completed the s. When asked about estorative nursing, she stated ible for the program.					
	p.m., registered nur restorative nursing therapy recommen- for monitoring the r 1/5/15. RN-B stated	2/26/15 at approximately 2:00 rse (RN)-B indicated the program was based on dations. RN-B was responsible estorative program as of d the facility had a restorative e process of hiring a he position.	9				
	SUGGESTED MET	HOD FOR CORRECTION:					
	could review policy appropriate restora provided. The DON or design appropriate staff or	sing (DON) and/or designee and procedures to ensure tive nursing care was nee could educate all the policies/procedures, and estorative nursing services					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00865	B. WING		02/2	27/2015
	PROVIDER OR SUPPLIER	5910 MIN	DRESS, CITY, ST NESOTA AVE MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	ige 11	2 915			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.134 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			
	Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.					
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure expired emoved from the medication ation carts.				
	Findings include:					
	the Lakeside unit w bottle of xalatan ey 12/4/14. Licensed F	p.m. the medication cart on vas observed to have one e drops with an open date of Practical Nurse (LPN)-B e drops expire 42 days after				
	the Bayside unit wa following expired m Nitrostat 0.4 milligra 5/31/13, and an exp of Nitrostat 0.3 mg and an expiration d Nitrostat 0.4 mg wit and an expiration d	p.m. the medication cart on as observed to have the redications: one bottle of ams (mg) dispense date of piration date of 5/14; one bottle with a dispense date of 1/1/14, ate of 1/15; one bottle of th a dispense date of 3/12/12, late of 3/13; and two bottles of pense date of 12/31/13, and an				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00865	B. WING		02/2	27/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVE MN 55802	NUE		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21610	expiration date of 1 verified the expirati On 2/26/15, at 1:42 (DON) was intervie carts should be che by the night nursing occasionally the fac medication carts fo The facility guidanc medications directs discarded 42 days facility policy and pr Medications directs outdated medicatio SUGGESTED MET The Director of Nur could develop, revie procedures to ensu removed from med areas. The Director of Nur could educate all a and procedures. The Director of Nur could develop mon	2/14. Registered nurse (RN)-D on dates. 2 p.m. the director of nursing wed and stated the medication ecked for expired medications g staff. The DON further stated cility pharmacy will check the r expired medications. We on when to discard e xalatan eye drops to be after opening. The undated rocedure on Storage of the facility should not used ns. THOD OF CORRECTION: rsing Services or designee ew, and/or revise policies and are expired medications were ication carts and storage rsing Services or designee opropriate staff on the policies rsing Services or designee itoring systems to ensure	21610	DEFICIENCY		
	ongoing compliance TIME PERIOD FOR Twenty-One (21) D	R CORRECTION:				
	Solid wastes, includ recyclables, and oth stored, and dispose	D Solid Waste Disposal ding garbage, rubbish, her refuse must be collected, ed of in a manner that will not or fire hazard, nor provide a	21735			

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00865	B. WING	B. WING		27/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVE	NUE		
		DULUIH,	MN 55802	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21735	Continued From pa	ige 13	21735			
	breeding place for i	nsects or rodents. mbustible material or waste in				
	by: Based on observati	ent is not met as evidenced ion, and interview the facility oper containment of garbage in ers.				
	facility's dumpster a dumpsters. One w garbage held the co feet. The other dur and the cover was	on 2/23/15, at 12:26 p.m., the area included two large as overflowing and bags of over open approximately 4-5 mpster was full of cardboard also open. Next to the ame was lying on the ground.				
	provided a tour of the garbage dumpster of 2-3 feet and M-A clue explained that one the other is for carco that waste manage Monday, Wednesda Monday mornings to overly full and open	9, maintenance (M)-A he facility dumpster area. The cover was open approximately osed the cover. M-A dumpster is for garbage and lboard recycling. M-A stated ment picked up garbage on ay and Friday. M-A stated the dumpsters were usually h. M-A stated when he osters open he would close				
	explained houseked bring bagged garba it in the green, wire facility staff as a "ca back door of the kit cart was full, mainte	2/25/15, at 12:39 p.m., M-A eping and other staff would age from the facility and place d, open wagon (referred to by art"). The cart stood next to the ichen. M-A stated when the enance and housekeeping dumpster and emptied it.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00865		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/27/2015		
						NAME OF I
RANCIS	SCAN HEALTH CENT	FR	NESOTA AVE , MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21735		age 14 / on 2/25/15, at 1:06 p.m. M-A ad no garbage policy.	21735			
	dumpster was agai open. In an intervie housekeeper (H)-A garbage to the cart housekeepers brou throughout the day and maintenance to	33 a.m., the cover of the in observed to be partially w on 2/26/15 at 10:09 a.m., stated night staff brought at the end of their shift. The ught garbage out to the cart . H-A stated housekeeping ransported garbage via the er as needed throughout the				
	The maintenance of develop, review, an procedures to ensu- disposal of garbage The maintenance of educate all appropri procedures. The maintenance of	THOD OF CORRECTION: director or designee could ad/or revise policies and ure the proper storage and e is maintained. director or designee could riate staff on the policies and director or designee could systems to ensure ongoing				
	TIME PERIOD FOI Twenty-One (21) D					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				

STATE FORM

3ZBK11

If continuation sheet 15 of 19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00865	B. WING		02/	02/27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FRANCI	SCAN HEALTH CENT	FR	INESOTA AVE , MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 15	21805			
	by: Based on observat review, the facility f toileting opportuniti R21). Findings include: R10's face sheet in included anxiety an Data Set (MDS) da a Brief Interview for of 7 (severely impa- incontinent, mostly indicated that she r with toileting or bed to check her during On 2/23/15, at 3:21 stated sometimes t further revealed sta I'm a nuisance, I do cried when they we she didn't say anytl was the crabby one R10 was interviewe a.m. and repeated crabby. She continu- her cry. R10 stated them anymore, but nurse. R10 continu- "I talk a lot." R10 fut "wake them" at nig bladder. R10 stated which she didn't like	ent is not met as evidenced ion, interview and document ailed to provide for dignified es for 2 of 2 residents (R10, depression. Her Minimum ted 1/15/15, indicated she had r Mental Status (BIMS) score ired) and was occasionally at night. R10's care plan required one person to assist d pan upon request. Staff was g first and last rounds at night. p.m. during interview R10 the staff was crabby. R10 aff had so much to do, "Maybe on't know." R10 stated she ere crabby to her. R10 stated hing because staff will say she e. ed again on 2/25/15 at 8:27 her statement that staff was ued to state one "gal" made d, "I just turned my head and I she didn't want to bother it's their job to be the night ued, saying "they're tired" and on the explained she hated to ht, but she can't control her ed they gave her a bed pan, e, but they're in a hurry. ation of R10' on 2/26/15 from				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
00		00865	B. WING	B. WING		27/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
FRANCI	SCAN HEALTH CENT	FR	INESOTA AVE , MN 55802	NUE			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5) COMPLET	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	HE APPROPRIATE	DATE	
21805	Continued From pa	age 16	21805				
	although staff enter offered toileting ser Director (AD)-A ent newspaper and tur stated that she war AD-A stated the sta bring R10's breakfa the room to get break breakfast tray at 7: 7:42 a.m. R10 state wet but not cold. At R10's room and ac nutritional supplem asked about break she was "getting us explained, "they're sometimes the "the she could have her R10 was interviewed repeated she was so I'm warm." NA-I a.m. to inform R10 she informed NA-E incontinence pad. 7 and R10 stated "OI stated "Boy I've be R10 then informed toileted or checked when toileted, R10 urine soaked with a assisting R10 in the bed was felt to be of folded the pad and When asked to fee back out, stated it we the pillow. R21 stated during it	8:20 a.m. revealed that red the room, no staff asked or rvices. At 7:27 a.m., Activity tered R10's room with the daily ned off the call light. R10 nted to get up for the day. aff were busy but she could ast. R10 agreed and AD-A left eakfast. AD-A returned with a 34 a.m. When interviewed at ed her incontinence pad was t 7:47 a.m., LPN-A entered diministered eye drops and a eent then left the room. When fast in bed, R10 replied that sed to it." She further so late, it's easier." She stated erapy lady" got her ready so r breakfast in the dining room. ed again at 8:10 a.m. and wet, but not cold; "I'm in bed, D entered the room at 8:30 she would get up soon, when 0 that she had a wet At 8:34 a.m. NA-D returned h boy am I wet." R10 also en laying there a long time." NA-D that she hadn't been I on all night. At 8:41 a.m. 's brief was observed to be a strong odor. While NA-D was e bathroom, the pad on the damp. At 8:56 a.m., NA-D tucked it under R10's pillow. el if it was wet, NA-D pulled it was dry and replaced it under					

STATEMEI	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00865		B. WING		02/	02/27/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FRANCI	SCAN HEALTH CENT	FR	INESOTA AVE , MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	and dignity. R21 sa she wants to. R21 she'll "simply have "night girl" came in longer go to the ba she would have to R21 stated she now was told she requir staff can't do it any was "fine" with the R21's MDS dated of 10 (moderate co indicated that she w (less than 7 episod was on a toileting p identified a pattern early a.m. related t was at risk of more need for assistance immobility and CV/ R21's current care approaches: *Assist of two with that provides stance requested, and *Offer assistance to R21's care plan lac is her preference to night. During interview or stated she got a be used to that" and g night. R21 stated, use the bathroom a During an interview NA-C stated R21 w	aid she doesn't get to bed when I stated staff come in and say to wait." R21 also identified a and informed her she could not throom at night. R21 told staff wet the bed then, and she did. w used the bed pan as she red too much assistance and more. R21 acknowledged she bedpan. 1/6/15, indicated a BIMS score ognitive impairment). The MDS was occasionally incontinent les in a week) of bladder and orogram. R21's care plan of urinary incontinence in the o her urge to void and that she e incontinence related to her e with toileting, her history of A (cerebral vascular accident). plan directed the following a PAL stand (mechanical lift ling assistance) to toilet as o toilet. cks evidence to support that it o always use a bed pan at				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00865	B. WING			27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RANCI	SCAN HEALTH CENT	FR	NNESOTA AVE	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	for residents who re as "most are incom the urge to urinate night and required used the bed pan a Upon interview on a director of nursing recent call light auc times in 7 days. Th an urge to go, and "teaspoon of urine, behavioral or anxie "wants to be a prine for the last month t night for R21. SUGGESTED MET The director of soc develop, review, an procedures to ensu- maintained. The director of soc educate all appropri- procedures. The director of soc	equired a two person transfer, tinent". NA-C stated R21 had "about every 20 minutes" at two people to transfer, so staff at night. 2/26/15 at 1:11 p.m. the (DON) explained that in a dit, R21 used her call light 198 he DON stated that R21 had sometime there is just a " and it was actually a ety issue. The DON stated R21 cess". The DON verified that hey were using the bed pan at THOD OF CORRECTION: ial services or designee could nd/or revise policies and ure all residents' dignity is ial services or designee could riate staff on the policies and ial services or designee could pystems to ensure ongoing R CORRECTION:				