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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 3ZBK

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

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

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 44 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Chris Campbell, Unit Supervisor — 04/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 04/22/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245258 | A. Building<br>B. Wing | 4/13/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| FRANCISCAN HEALTH CENTER | 3910 MINNESOTA AVENUE<br>DULUTH, MN 55802 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0241**<br>Reg. # **483.15(a)**<br>LSC | Correction Completed **04/07/2015** | ID Prefix **F0278**<br>Reg. # **483.20(g) - (j)**<br>LSC | Correction Completed **04/07/2015** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **04/07/2015** |
| ID Prefix **F0311**<br>Reg. # **483.25(a)(2)**<br>LSC | Correction Completed **04/07/2015** | ID Prefix **F0315**<br>Reg. # **483.25(d)**<br>LSC | Correction Completed **04/07/2015** | ID Prefix **F0372**<br>Reg. # **483.35(i)(3)**<br>LSC | Correction Completed **04/07/2015** |
| ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **04/07/2015** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | CC/mm | 04/14/2015 | 13922 | 04/13/2015 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 2/27/2015 | | | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 3ZBK

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

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(L3) **FRANCISCAN HEALTH CENTER**
(L4) **3910 MINNESOTA AVENUE**
(L5) **DULUTH, MN** (L6) **55802**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 44 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NEII — 04/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 04/21/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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;**

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

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

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

**DEPARTMENT CONTACT**

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

**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

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.

## 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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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 5258s15

Franciscan Health Center
3910 Minnesota Avenue ■ Duluth, Minnesota 55802 ■ Telephone: (218) 727-8933
Fax: (218) 727-6610



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

Deborah De Grio

Administrator

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

RECEIVED
MAR 27 2015
MN Dept of Health
Duluth

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. | F 000 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide for dignified toileting opportunities for 2 of 2 residents (R10, R21).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15, indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally | F 241 | OK'd addendum 4/1/15 E | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Deborah DeGrio | Administrator | 3-27-2015 |

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

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| F 241 | Continued From page 1 | F 241 | | |

incontinent, mostly at night. R10's care plan indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.

On 2/23/15, at 3:21 p.m. during interview R10 stated sometimes the staff was crabby. R10 further revealed staff had so much to do, "Maybe I'm a nuisance, I don't know." R10 stated she cried when they were crabby to her. R10 stated she didn't say anything because staff will say she was the crabby one.

R10 was interviewed again on 2/25/15 at 8:27 a.m. and repeated her statement that staff was crabby. She continued to state one "gal" made her cry. R10 stated, "I just turned my head and cried." R10 stated she didn't want to bother them anymore, but it's their job to be the night nurse. R10 continued, saying "they're tired" and "I talk a lot." R10 further explained she hated to "wake them" at night, but she can't control her bladder. R10 stated they gave her a bed pan, which she didn't like, but they're in a hurry.

Continuous observation of R10' on 2/26/15 from 4:33 a.m. through 8:20 a.m. revealed that although staff entered the room, no staff asked or offered toileting services. At 7:27 a.m., Activity Director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a

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nutritional supplement then left the room. When asked about breakfast in bed, R10 replied that she was "getting used to it." She further explained, "they're so late, it's easier." She stated sometimes the "therapy lady" got her ready so she could have her breakfast in the dining room. R10 was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon, when she informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." R10 then informed NA-D that she hadn't been toileted or checked on all night. At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor. While NA-D was assisting R10 in the bathroom, the pad on the bed was felt to be damp. At 8:56 a.m., NA-D folded the pad and tucked it under R10's pillow. When asked to feel if it was wet, NA-D pulled it back out, stated it was dry and replaced it under the pillow.

R21 stated during interview on 2/24/15, at 8:37 a.m., that lately staff didn't treat her with respect and dignity. R21 said she doesn't get to bed when she wants to. R21 stated staff come in and say she'll "simply have to wait." R21 also identified a "night girl" came in and informed her she could no longer go to the bathroom at night. R21 told staff she would have to wet the bed then, and she did. R21 stated she now used the bed pan as she was told she required too much assistance and staff can't do it anymore. R21 acknowledged she was "fine" with the bedpan.

R21's MDS dated 1/6/15, indicated a BIMS score

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| F 241 | Continued From page 3<br>of 10 (moderate cognitive impairment). The MDS indicated that she was occasionally incontinent (less than 7 episodes in a week) of bladder and was on a toileting program. R21's care plan identified a pattern of urinary incontinence in the early a.m. related to her urge to void and that she was at risk of more incontinence related to her need for assistance with toileting, her history of immobility and CVA (cerebral vascular accident). R21's current care plan directed the following approaches:<br>*Assist of two with a PAL stand (mechanical lift that provides standing assistance) to toilet as requested, and<br>*Offer assistance to toilet.<br>R21's care plan lacks evidence to support that it is her preference to always use a bed pan at night.<br><br>During interview on 2/25/15, at 1:36 p.m., R21 stated she got a bed pan at night. She said, "I'm used to that" and guessed that everyone did at night. R21 stated, "I don't think anyone gets to use the bathroom at night."<br><br>During an interview on 2/26/15, at 5:17 a.m., NA-C stated R21 was a two person transfer and for about two months staff used bed pans at night for residents who required a two person transfer, as "most are incontinent". NA-C stated R21 had the urge to urinate "about every 20 minutes" at night and required two people to transfer, so staff used the bed pan at night.<br><br>Upon interview on 2/26/15 at 1:11 p.m. the director of nursing (DON) explained that in a recent call light audit, R21 used her call light 198 times in 7 days. The DON stated that R21 had an urge to go, and sometime there is just a | F 241 |



**F241**

FHC provides dignified toileting opportunities for all residents
R10 was re-interviewed regarding use of a bedpan during the NOC shift.
The resident was also re-interviewed about her preference for getting up
for the continental breakfast or receiving a tray in her room.
SS/Nurse Manager did meet with resident and revised her POC per her request.
R21 was re-interviewed regarding the use of a bedpan during the NOC Shift. The resident was also re-interviewed regarding what time she would like to go to bed. Her care plan was revised per her request.
All residents are being interviewed about their toileting requests and care plans will be changed according to their preference by 4-4-15

All residents are being interviewed about their awakening/eating preferences with completion by 4-4-15

All newly admitted residents will be interviewed upon admission and preference of toileting and awaking will be care planned according to their request.

All newly admitted residents we be interviewed upon admission and preference of awakening/eating will be documented per their choice.

All residents will be interviewed moving forward during their quarterly care conference and PRN to ensure preference is being met.

1. NAR care sheets will be revised accordingly.
2. Care plans will be updated accordingly
3. Random audits will be conducted by the DON/Nurse Manager/Social Service and the Administrator to ensure compliance 3 times a week x 4 weeks. 2x a week x 4 then weekly ongoing
4. Results will be brought to the QAPI Committee for review and further recommendations

All staff have been educated on 2-28-2015 and again on 4-1-2015 and 4-2-2015

Completion date: 4-7-15

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| F 241 | Continued From page 4<br>"teaspoon of urine," and it was actually a behavioral or anxiety issue. The DON stated R21 "wants to be a princess". The DON verified that for the last month they were using the bed pan at night for R21. | F 241 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced | F 278 | F278 Accurate MDS<br><br>FHC aspires to have accurate information on the MDS<br><br>R7's Annual DMS was a miscoding and was modified on 2-27-2015 according the MDS Manual<br><br>All MDS's will be audited by the MDS Coordinator to ensure that all coding is checked correctly in Section L with completion date of 3-27-15<br><br>All MDS's will be audited by the MDS Coordinator, Nurse Managers and DON. Random Audits will be completed 2x per week x 4 then weekly thereafter with the results brought back to the QAPI Committee for review and further recommendations.<br><br>All nursing staff have been educated on 3-18-2015 and again on 4-1-2015 and 4-2-2015<br>Completion date: 4-7-15 | |

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| F 278 | Continued From page 5<br>by:<br>Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 1 residents (R7) reviewed for dental status/activities of daily living.<br><br>Findings include:<br><br>R7's Admission Information as of 2/26/15, indicated R7's diagnoses included cerebrovascular disease, anemia, hydrocephalus, secondary Parkinsonism, flaccid hemiplegia of the dominant side, trigeminal neuralgia and cardiovascular disease.<br><br>An oral assessment dated 11/15/14, indicated R7 had no teeth present in the upper gums and the lower gums had several black rough tooth fragments.<br><br>The oral care plan dated 6/19/14, indicated R7 had only tooth fragments imbedded in the gums.<br><br>The annual MDS dated 11/26/14, indicated R7 had no dental problems.<br><br>On 2/24/15, at 10:05 a.m. R7's teeth were observed. R7 did not have any upper teeth present and on the bottom R7 had three to four broken and black teeth with one larger tooth on the lower left side that was broken and jagged.<br><br>On 2/26/15, at 9:25 a.m. registered nurse (RN)-B verified the annual MDS dated 11/26/14 was incorrect. RN-B stated the annual MDS should have been coded as obvious or likely cavities or broken natural teeth. | F 278 | | |

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| F 278 | Continued From page 6<br><br>The facility's MDS 3.0 Assessment policy reviewed and amended on 7/19/13, indicated the MDS coordinator was responsible for conducting audits to identify errors and make the appropriate corrections prior to submitting the MDS to ensure the information was accurate. | F 278 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow the care plan regarding toileting for 1 of 2 residents (R10).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15 indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally incontinent, mostly at night. R10's care plan indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.<br><br>On 2/25/15, at approximately 2:30 p.m. nursing assistant (NA)-D stated that R10 was a fairly accurate reporter. NA-D explained R10 was not reliable for length of time. NA-D then clarified R10 | F 282 | | |

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

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| F 282 | Continued From page 7<br>would say she waited a half-hour when it's only been 5 minutes. She was otherwise a reliable reporter.<br><br>Continuous observation of R10 on 2/26/15 from 4:33 a.m. through 8:20 a.m. revealed that although staff entered R10's room, no staff asked or offered toileting services. At 7:27 a.m., activity director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a nutritional supplement then left the room. R10 was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon,R10 then informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor.<br><br>During an interview on 2/26/15, at approximately 8:10 a.m., NA-D stated he was unable to get the work done, specifically repositioning and check/changes. NA-D stated he usually didn't receive report or his group list from night shift, so he was unable to state when R10 was last toileted. | F 282 |
| F 311 | 483.25(a)(2) TREATMENT/SERVICES TO | F 311 |



**F282**

**FHC provides care and services according to the resident plan of care**

**R10 was re-interviewed regarding use of a bedpan during the NOC shift.**
**The resident was also re-interviewed about her preference for getting up with care plan update**
**for the continental breakfast or receiving a tray in her room. Her care plan was revised with her preference of toileting and awaking/meals.**

**All newly admitted residents will be interviewed for preference choice and care planned according to their wishes. All current residents will be interviewed for toileting preference with changes to the plan of care will be made accordingly**
**All newly admitted residents will be interviewed for preference choice and care planned according to their wishes. All current residents will be interviewed for meal time preference with changes to the plan of care will be made accordingly.**

1. **NAR care sheets were revised and the NARs will carry them in their pockets**
2. **Shift report will be conducted at the beginning of each shift with the prior shift letting oncoming shift know when the residents were last toileted**
3. **Random audits will be conducted by DON/Nurse Manager/Administrator 3 x a week x 4 weeks for compliance of both shift reporting and toileting and meal preference to ensure both are being followed. If compliance is met will continue with auditing of reporting and toileting preferences weekly thereafter. Results will be brought to the QAPI Committee for review and further recommendations**

**All staff have been re- educated on 2-28-2015 and again on 4-01-2015 and 4-2-2015**

**Completion Date** 4-7-15

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| F 311 SS=D | Continued From page 8<br>IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide restorative nursing services for ambulation for 1 of 3 residents (R53).<br><br>Findings include:<br><br>Review of R53's face sheet indicated he was admitted on 10/6/14. R53's admission diagnoses included subdural hemorrhage (bleeding that occurs between the surface of the brain and the thin layer of tissue that separates the brain from the skull]) and neuritis (a change in the state of the nerves resulting in weakness, loss of the reflexes and changes of sensation).<br><br>R53's admission Minimum Data Set (MDS) dated 10/13/14, and quarterly MDS dated 1/6/15, specified he needed extensive assistance with his ambulation.<br><br>Review of physical and occupational therapy notes, revealed that R53 received physical and occupational therapy from 10/6/14 to 12/19/14. The notes indicated that at the time of therapy discharge, R53 required contact guard assistance with one assist and a walker.<br><br>Physical and occupational therapy referred R53 to restorative nursing at the time of discharge from therapy. Review of R53's restorative nursing | F 311 | | |

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| F 311 | Continued From page 9<br>program documents indicated the program had been scheduled to begin on 12/22/14.<br><br>The physical therapist specified the restorative nursing program should focus on transfers and ambulation. The physical therapist directed the restorative nursing program to include:<br>· Walk with walker and contact guard assist (CGA) (routinely required contact with patient due to unsteadiness during transfer) with belt and one staff assist.<br>· Walk for 100-200 feet twice daily.<br>· Staff was encouraged to cue resident to lock wheelchair brakes and push up with hands from wheelchair.<br><br>Review of R53's documentation revealed the restorative plans were not implemented until 1/7/15. Review of R53's care plan dated 1/5/15, identified his restorative plan for walking was to be offered twice a day 4-7 days per week.<br><br>Specifically, R53's restorative documents indicated:<br>1/7/15: walking distance 100 feet, 5 minutes, meeting goal<br>1/13/15: walking distance of 110 feet, 10 minutes, meeting goal<br>1/20/15: walking distance of 130 feet, 14 minutes, meeting goal<br>In January R53 received ambulation services 3 times in 28 to 48 opportunities.<br>Review of R53's restorative documentation indicated he also received restorative services for ambulation on 2/3/15, 2/4/15, 2/5/15, 2/10/15, 2/11/15, 2/12/15, 2/13/15 and 2/24/15. In February R53 ambulated 8 times in 32 to 54 opportunities. | F 311 | | |

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| F 311 | Continued From page 10<br>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 12/19/14, R53 had reached his maximum potential of CGA.<br><br>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 abilities in January and requested a reassessment. OT-A and PT-A stated they completed evaluations for R53 on 1/26/15, and identified a "significant decline" in R53's abilities.<br><br>Review of the physical therapy initial assessment dated 1/26/15, supported the decline, specifically:<br>Transfers - sit to stand: prior level CGA to current level of moderate assistance (routinely requires 50% physical assistance to transfer).<br>Transfers - stand to sit: prior level CGA to current level of moderate assistance.<br>Transfers - stand and pivot: prior level CGA to current level of moderate assistance. The physical therapy plan of care dated 1/26/15, indicated the family had noticed a decline approximately a week before which resulted in R53 requiring significantly more assistance for the completion of transfers and ambulation.<br><br>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 | | |

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| F 311 | Continued From page 11 | F 311 | | |

and OT-A indicated they planned to continue working on R53's standing balance and transfers. They intended to get R53 back to his previous maximum potential, and keep him on a bit longer to see if they can gain greater improvements before discharging to restorative nursing.

In an interview on 2/25/15, at 9:50 a.m., nursing assistant (NA)-F indicated the availability of a restorative aide was "variable." NA-F thought the facility had posted for a full time position. In the meantime, the floor nursing assistants were to pick up the restorative work. NA-F stated there are 4-5 aides working during the day. NA-F stated after completing the restorative, aides always recorded the work in a book at the nurse's station. However, in the last week or so they were beginning to record restorative services in the computerized record.

In an interview on 2/26/2015 at 1:09 p.m., the nurse manager, registered nurse (RN)-C indicated they were in the process of hiring a full-time restorative aide. She stated that a restorative aide position was in addition to the current floor staff. When there was no restorative aide, the floor nursing assistants completed the restorative services. When asked about monitoring of the restorative nursing, she stated RN-B was responsible for the program.

In an interview on 2/26/15 at approximately 2:00 p.m., registered nurse (RN)-B indicated the restorative nursing program was based on therapy recommendations. RN-B was responsible for monitoring the restorative program as of 1/5/15. RN-B stated the facility had a restorative aide and were in the process of hiring a replacement to fill the position.

**F311**

**FHC provides the appropriate treatment and services to our residents in order to maintain or improve their abilities.**

**R53 was in Physical Therapy during the survey and continued until 3-13-2015**

**A restorative ambulation program was initiated on 3-15-2015 and placed on the NAR Care sheet and in his care plan.**

**All restorative ambulation programs were reviewed, revised and placed on the NAR Care sheets by 3-27-2015.**

**All NAR's were trained on putting the Restorative minutes into the EMR kiosk by 3-25-2015**

**Random audits of the NAR documentation on the restorative Program will be conducted by the MDS Coordinator, DON, Nurse Managers and Administrator daily x2 weeks, then 2x week x2 weeks and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.**

**All staff were educated on 2-28-2015 and again on 4-1-2014 and 4-2-2015**

**Completion Date** 4-7-15

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure toileting was provided for 1 of 2 residents (R10).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15 indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally incontinent, mostly at night. R10's Care Area Assessment dated 1/29/15, identified she needed assistance from one staff member to toilet and she was occasionally incontinent, especially at night. R10's care plan dated 1/19/15, indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.<br><br>R10 was interviewed on 2/25/15, at 8:27 a.m., and stated she didn't like to bother the night staff but she couldn't control her bladder and | F 315 | **F315**<br>**FHC ensures toileting is being provided for our residents**<br>**R10 was re-interviewed regarding toileting preferences and the plan of care was revised accordingly.**<br>**R10 NAR care sheet was revised.**<br>**Shift report will be conducted at the beginning of the shift with prior shift letting oncoming shift when the residents were last toileted.**<br>**Random audits will be conducted by DON/Nurse Mangers regarding shift report being conducted and the use of the NAR Care sheets, 3x week x2, then 2x week x2 and weekly thereafter.**<br>**Random audits will be conducted by the DON/Nurse Mangers on each resident's toileting preferences ensuring they are being followed, 3x a week x 2, then 2x week x2 then weekly thereafter.**<br>**Audit results will be brought to the QAPI Committee for review and further recommendations.**<br>**All staff have been educated on 2-28-2015 and again on 4-1-2015 and 4-2-2015**<br><br>**Completion date:** 4-2-15 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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| FRANCISCAN HEALTH CENTER | 3910 MINNESOTA AVENUE DULUTH, MN 55802 |

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|---|---|---|---|---|
| F 315 | Continued From page 13<br>aknowledged needing staff assistance with toileting.<br><br>On 2/25/15, at approximately 2:30 p.m. nursing assistant (NA)-D stated that R10 was a fairly accurate reporter. NA-D explained R10 was not reliable for length of time. NA-D then clarified R10 would say she waited a half-hour when it's only been 5 minutes. She was otherwise a reliable reporter.<br><br>Continuous observation of R10 on 2/26/15, from 4:33 a.m. through 8:20 a.m. revealed that although staff entered the room, no staff asked or offered toileting services. At 7:27 a.m., activity director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a nutritional supplement then left the room. R10 was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon, at that time she informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." R10 then informed NA-D that she hadn't been toileted or checked on all night. At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor. | F 315 | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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

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| F 372 | Continued From page 14 | F 372 | | |
| F 372 SS=C | 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY<br><br>The facility must dispose of garbage and refuse properly.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and interview the facility failed to ensure proper containment of garbage in the outside dumpsters.<br><br>During observation on 2/23/15, at 12:26 p.m., the facility's dumpster area included two large dumpsters. One was overflowing and bags of garbage held the cover open approximately 4-5 feet. The other dumpster was full of cardboard and the cover was also open. Next to the dumpsters a bed frame was lying on the ground.<br><br>On 2/25/15, at 12:39, maintenance (M)-A provided a tour of the facility dumpster area. The garbage dumpster cover was open approximately 2-3 feet and M-A closed the cover. M-A explained that one dumpster is for garbage and the other is for cardboard recycling. M-A stated that waste management picked up garbage on Monday, Wednesday and Friday. M-A stated Monday mornings the dumpsters were usually overly full and open. M-A stated when he observed the dumpsters open he would close them.<br><br>During the tour on 2/25/15, at 12:39 p.m., M-A explained housekeeping and other staff would bring bagged garbage from the facility and place it in the green, wired, open wagon (referred to by facility staff as a "cart"). The cart stood next to the | F 372 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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| FRANCISCAN HEALTH CENTER | 3910 MINNESOTA AVENUE DULUTH, MN 55802 |

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|---|---|---|---|
| F 372 | Continued From page 15<br>back door of the kitchen. M-A stated when the cart was full, maintenance and housekeeping took the cart to the dumpster and emptied it.<br><br>During an interview on 2/25/15, at 1:06 p.m. M-A stated the facility had no garbage policy.<br><br>On 2/26/2015 at 4:33 a.m., the cover of the dumpster was again observed to be partially open. In an interview on 2/26/15 at 10:09 a.m., housekeeper (H)-A stated night staff brought garbage to the cart at the end of their shift. The housekeepers brought garbage out to the cart throughout the day. H-A stated housekeeping and maintenance transported garbage via the cart to the dumpster as needed throughout the day. | F 372 | **F372**<br>**FHC will ensure that garbage will be disposed of properly.**<br>**A policy has been developed in the proper disposal of garbage from the facility and once it is placed in the containers supplied by the garbage company.**<br>**Waste Management has been notified that once garbage pickup is completed the driver must ensure that the lid of the garbage container is closed properly.**<br>**Once the weather is cooperative lettering will also be placed on the garbage containers to remind everyone that they need to be closed at all times.**<br>**Staff have been educated that they cannot leave any garbage in the green cart outside of the facility but instead must take it directly to the garbage container for disposal.**<br>**Audits will be conducted daily by EES, Housekeeping and Administrator to ensure compliance.**<br>**All staff have been educated on 2-28-2015 and again on 4-1-2015 and 4-2-2015**<br><br>**Results of audits will be brought to the QAPI Committee for review and further recommendations**<br>**Completion date:** 4-7-15 |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in | F 431 | |

| ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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| :RANCISCAN HEALTH CENTER | 3910 MINNESOTA AVENUE DULUTH, MN 55802 |

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|---|---|---|---|---|
| F 431 | Continued From page 16<br>locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medications were removed from the medication cart in 2 of 2 medication carts.<br><br>Findings include:<br><br>On 2/26/15, at 1:03 p.m. the medication cart on the Lakeside unit was observed to have one bottle of xalatan eye drops with an open date of 12/4/14. Licensed Practical Nurse (LPN)-B verified xalatan eye drops expire 42 days after opening.<br><br>On 2/26/15, at 1:10 p.m. the medication cart on the Bayside unit was observed to have the following expired medications: one bottle of Nitrostat 0.4 milligrams (mg) dispense date of 5/31/13, and an expiration date of 5/14; one bottle of Nitrostat 0.3 mg with a dispense date of 1/1/14, and an expiration date of 1/15; one bottle of | F 431 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING _____ B. WING _____ | 02/27/2015 |

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|---|---|---|---|---|
| F 431 | Continued From page 17<br>Nitrostat 0.4 mg with a dispense date of 3/12/12, and an expiration date of 3/13; and two bottles of Nitrostat with a dispense date of 12/31/13, and an expiration date of 12/14. Registered nurse (RN)-D verified the expiration dates.<br><br>On 2/26/15, at 1:42 p.m. the director of nursing (DON) was interviewed and stated the medication carts should be checked for expired medications by the night nursing staff. The DON further stated occasionally the facility pharmacy will check the medication carts for expired medications.<br><br>The facility guidance on when to discard medications directs xalatan eye drops to be discarded 42 days after opening. The undated facility policy and procedure on Storage of Medications directs the facility should not used outdated medications. | F 431 | **F431 Expired meds**<br>**FHC will ensure all expired medications are removed from the med carts.**<br>**Night shift is assigned to check carts for expired medications weekly.**<br>**Audits of the med carts will be conducted by the DON/Nurse Managers 3x week x2 weeks, then 2x week x2, and on a weekly basis there after to ensure all expired medications have been removed and discarded.**<br>**Audit results will be brought to the QAPI Committee for review and further recommendations**<br>**All staff have been re-educated on 2-28-2015 and again on 4-1-2015 and 4-2-2015**<br><br>**Completion date:** 4-7-2015 | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/24/2015** |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Franciscan Health Center, Building #1, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19, Existing Health Care.<br><br>Franciscan Health Center Building #1 is a 2 story building with a small partial basement. The 2nd level is all office space with no resident access The building was constructed at 2 different times.<br><br>The original building was constructed in 1960 and was determined to be of Type II(000) construction. In 1970 an addition was constructed that was determined to also be of Type II(00) construction. Because the original building and the addition meet the construction type for existing buildings, this building was surveyed to Chapter 19, existing health care.<br><br>This building is fully fire sprinkler protected. The entire facility has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor.<br><br>Building #1 is properly 2 hour fire separated from building #2 which was constructed in 2006<br><br>The facility has a licensed capacity of 44 beds and had a census of 41 at the time of the survey.<br><br>The requirement at 42 CFR Subpart 483.70(a) is | K 000 | | |

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

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/24/2015** |

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

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| K 000 | Continued From page 1<br>Met. | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245258 | A. BUILDING **02 - FRANCISCAN HEATLH CENTER** B. WING _____ | **02/24/2015** |

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

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| K 000 | INITIAL COMMENTS<br><br>Juntunen, Jeff<br>FIRE SAFETY<br><br>THIS INSPECTION ONLY COVERS THE 2006 ADDITION TO FRANCISCAN HEALTH CENTER.<br><br>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.<br><br>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.<br><br>The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 44 and a census of 39 at the time of inspection<br><br>The requirement at 42 CFR Subpart 483.70(a) is met. | K 000 | | |

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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 only a suggestion 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.

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**

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 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(s)

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00865 | A. BUILDING: _____ B. WING _____ | 02/27/2015 |

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| FRANCISCAN HEALTH CENTER | 3910 MINNESOTA AVENUE DULUTH, MN 55802 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On February 23, 24, 25, 26 and 27, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of | 2 000 | 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. | |

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| 2 000 | Continued From page 1<br>Compliance Monitoring, Licensing and Certification Program, Christine Campbell, 11 East Superior St., #290, Duluth, MN 55802. | 2 000 | 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 which 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced | 2 565 | | |

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| 2 565 | Continued From page 2<br>by:<br>Based on observation, interview and document review, the facility failed to follow the care plan regarding toileting for 1 of 2 residents (R10).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15 indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally incontinent, mostly at night. R10's care plan indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.<br><br>On 2/25/15, at approximately 2:30 p.m. nursing assistant (NA)-D stated that R10 was a fairly accurate reporter. NA-D explained R10 was not reliable for length of time. NA-D then clarified R10 would say she waited a half-hour when it's only been 5 minutes. She was otherwise a reliable reporter.<br><br>Continuous observation of R10 on 2/26/15 from 4:33 a.m. through 8:20 a.m. revealed that although staff entered R10's room, no staff asked or offered toileting services. At 7:27 a.m., activity director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a nutritional supplement then left the room. R10 | 2 565 | | |

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| 2 565 | Continued From page 3<br>was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon,R10 then informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor.<br><br>During an interview on 2/26/15, at approximately 8:10 a.m., NA-D stated he was unable to get the work done, specifically repositioning and check/changes. NA-D stated he usually didn't receive report or his group list from night shift, so he was unable to state when R10 was last toileted.<br><br>Suggested Method of Correction:<br><br>The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed.<br>The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.<br><br>Time Period for Correction: 21 days | 2 565 | | |
| 2 910 | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence<br><br>Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the | 2 910 | | |

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| 2 910 | Continued From page 4<br>comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and<br>B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure toileting was provided for 1 of 2 residents (R10).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15 indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally incontinent, mostly at night. R10's Care Area Assessment dated 1/29/15, identified she needed assistance from one staff member to toilet and she was occasionally incontinent, especially at night. R10's care plan dated 1/19/15, indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.<br><br>R10 was interviewed on 2/25/15, at 8:27 a.m., and stated she didn't like to bother the night staff but she couldn't control her bladder and aknowledged needing staff assistance with | 2 910 | | |

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| 2 910 | Continued From page 5<br>toileting.<br><br>On 2/25/15, at approximately 2:30 p.m. nursing assistant (NA)-D stated that R10 was a fairly accurate reporter. NA-D explained R10 was not reliable for length of time. NA-D then clarified R10 would say she waited a half-hour when it's only been 5 minutes. She was otherwise a reliable reporter.<br><br>Continuous observation of R10 on 2/26/15, from 4:33 a.m. through 8:20 a.m. revealed that although staff entered the room, no staff asked or offered toileting services. At 7:27 a.m., activity director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a nutritional supplement then left the room. R10 was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon, at that time she informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." R10 then informed NA-D that she hadn't been toileted or checked on all night. At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor.<br><br>SUGGESTED METHOD OF CORRECTION: | 2 910 | | |

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| 2 910 | Continued From page 6<br><br>The director of nursing or her designee could develop policies and procedures to ensure residents receive appropriate toileting services as determined necessary by their individualized assessment and directed by the plan of care. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 2 910 | | |
| 2 915 | MN Rule 4658.0525 Subp. 6 A Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:<br>(1) bathe, dress, and groom;<br>(2) transfer and ambulate;<br>(3) use the toilet;<br>(4) eat; and<br>(5) use speech, language, or other functional communication systems; and<br><br>This MN Requirement is not met as evidenced | 2 915 | | |

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| 2 915 | Continued From page 7<br>by:<br>Based on interview and document review, the facility failed to provide restorative nursing services for ambulation for 1 of 3 residents (R53).<br><br>Findings include:<br><br>Review of R53's face sheet indicated he was admitted on 10/6/14. R53's admission diagnoses included subdural hemorrhage (bleeding that occurs between the surface of the brain and the thin layer of tissue that separates the brain from the skull]) and neuritis (a change in the state of the nerves resulting in weakness, loss of the reflexes and changes of sensation).<br><br>R53's admission Minimum Data Set (MDS) dated 10/13/14, and quarterly MDS dated 1/6/15, specified he needed extensive assistance with his ambulation.<br><br>Review of physical and occupational therapy notes, revealed that R53 received physical and occupational therapy from 10/6/14 to 12/19/14. The notes indicated that at the time of therapy discharge, R53 required contact guard assistance with one assist and a walker.<br><br>Physical and occupational therapy referred R53 to restorative nursing at the time of discharge from therapy. Review of R53's restorative nursing program documents indicated the program had been scheduled to begin on 12/22/14.<br><br>The physical therapist specified the restorative nursing program should focus on transfers and ambulation. The physical therapist directed the restorative nursing program to include:<br>· Walk with walker and contact guard assist (CGA) (routinely required contact with patient due | 2 915 | | |

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| 2 915 | Continued From page 8<br>to unsteadiness during transfer) with belt and one staff assist.<br>· Walk for 100-200 feet twice daily.<br>· Staff was encouraged to cue resident to lock wheelchair brakes and push up with hands from wheelchair.<br><br>Review of R53's documentation revealed the restorative plans were not implemented until 1/7/15. Review of R53's care plan dated 1/5/15, identified his restorative plan for walking was to be offered twice a day 4-7 days per week.<br><br>Specifically, R53's restorative documents indicated:<br>1/7/15: walking distance 100 feet, 5 minutes, meeting goal<br>1/13/15: walking distance of 110 feet, 10 minutes, meeting goal<br>1/20/15: walking distance of 130 feet, 14 minutes, meeting goal<br>In January R53 received ambulation services 3 times in 28 to 48 opportunities.<br>Review of R53's restorative documentation indicated he also received restorative services for ambulation on 2/3/15, 2/4/15, 2/5/15, 2/10/15, 2/11/15, 2/12/15, 2/13/15 and 2/24/15. In February R53 ambulated 8 times in 32 to 54 opportunities.<br><br>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 12/19/14, R53 had reached his maximum potential of CGA. | 2 915 | | |

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| 2 915 | Continued From page 9<br><br>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 abilities in January and requested a reassessment. OT-A and PT-A stated they completed evaluations for R53 on 1/26/15, and identified a "significant decline" in R53's abilities.<br><br>Review of the physical therapy initial assessment dated 1/26/15, supported the decline, specifically:<br>Transfers - sit to stand: prior level CGA to current level of moderate assistance (routinely requires 50% physical assistance to transfer).<br>Transfers - stand to sit: prior level CGA to current level of moderate assistance.<br>Transfers - stand and pivot: prior level CGA to current level of moderate assistance. The physical therapy plan of care dated 1/26/15, indicated the family had noticed a decline approximately a week before which resulted in R53 requiring significantly more assistance for the completion of transfers and ambulation.<br><br>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 and OT-A indicated they planned to continue working on R53's standing balance and transfers. They intended to get R53 back to his previous maximum potential, and keep him on a bit longer to see if they can gain greater improvements before discharging to restorative nursing.<br><br>In an interview on 2/25/15, at 9:50 a.m., nursing assistant (NA)-F indicated the availability of a restorative aide was "variable." NA-F thought the facility had posted for a full time position. In the | 2 915 | | |

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| 2 915 | Continued From page 10<br>meantime, the floor nursing assistants were to pick up the restorative work. NA-F stated there are 4-5 aides working during the day. NA-F stated after completing the restorative, aides always recorded the work in a book at the nurse's station. However, in the last week or so they were beginning to record restorative services in the computerized record.<br><br>In an interview on 2/26/2015 at 1:09 p.m., the nurse manager, registered nurse (RN)-C indicated they were in the process of hiring a full-time restorative aide. She stated that a restorative aide position was in addition to the current floor staff. When there was no restorative aide, the floor nursing assistants completed the restorative services. When asked about monitoring of the restorative nursing, she stated RN-B was responsible for the program.<br><br>In an interview on 2/26/15 at approximately 2:00 p.m., registered nurse (RN)-B indicated the restorative nursing program was based on therapy recommendations. RN-B was responsible for monitoring the restorative program as of 1/5/15. RN-B stated the facility had a restorative aide and were in the process of hiring a replacement to fill the position.<br><br>SUGGESTED METHOD FOR CORRECTION:<br><br>The director of nursing (DON) and/or designee could review policy and procedures to ensure appropriate restorative nursing care was provided.<br>The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure restorative nursing services were provided and documented. | 2 915 | | |

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| 2 915 | Continued From page 11<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 915 | | |
| 21610 | MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure expired medications were removed from the medication cart in 2 of 2 medication carts.<br><br>Findings include:<br><br>On 2/26/15, at 1:03 p.m. the medication cart on the Lakeside unit was observed to have one bottle of xalatan eye drops with an open date of 12/4/14. Licensed Practical Nurse (LPN)-B verified xalatan eye drops expire 42 days after opening.<br><br>On 2/26/15, at 1:10 p.m. the medication cart on the Bayside unit was observed to have the following expired medications: one bottle of Nitrostat 0.4 milligrams (mg) dispense date of 5/31/13, and an expiration date of 5/14; one bottle of Nitrostat 0.3 mg with a dispense date of 1/1/14, and an expiration date of 1/15; one bottle of Nitrostat 0.4 mg with a dispense date of 3/12/12, and an expiration date of 3/13; and two bottles of Nitrostat with a dispense date of 12/31/13, and an | 21610 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 21610 | Continued From page 12<br>expiration date of 12/14. Registered nurse (RN)-D verified the expiration dates.<br><br>On 2/26/15, at 1:42 p.m. the director of nursing (DON) was interviewed and stated the medication carts should be checked for expired medications by the night nursing staff. The DON further stated occasionally the facility pharmacy will check the medication carts for expired medications.<br><br>The facility guidance on when to discard medications directs xalatan eye drops to be discarded 42 days after opening. The undated facility policy and procedure on Storage of Medications directs the facility should not used outdated medications.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure expired medications were removed from medication carts and storage areas.<br>The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures.<br>The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) Days | 21610 | | |
| 21735 | MN Rule 4658.1420 Solid Waste Disposal<br><br>Solid wastes, including garbage, rubbish, recyclables, and other refuse must be collected, stored, and disposed of in a manner that will not create a nuisance or fire hazard, nor provide a | 21735 | | |

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| | 00865 | A. BUILDING: _____ B. WING _____ | 02/27/2015 |

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| 21735 | Continued From page 13<br>breeding place for insects or rodents. Accumulation of combustible material or waste in unassigned areas is prohibited.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, and interview the facility failed to ensure proper containment of garbage in the outside dumpsters.<br><br>During observation on 2/23/15, at 12:26 p.m., the facility's dumpster area included two large dumpsters. One was overflowing and bags of garbage held the cover open approximately 4-5 feet. The other dumpster was full of cardboard and the cover was also open. Next to the dumpsters a bed frame was lying on the ground.<br><br>On 2/25/15, at 12:39, maintenance (M)-A provided a tour of the facility dumpster area. The garbage dumpster cover was open approximately 2-3 feet and M-A closed the cover. M-A explained that one dumpster is for garbage and the other is for cardboard recycling. M-A stated that waste management picked up garbage on Monday, Wednesday and Friday. M-A stated Monday mornings the dumpsters were usually overly full and open. M-A stated when he observed the dumpsters open he would close them.<br><br>During the tour on 2/25/15, at 12:39 p.m., M-A explained housekeeping and other staff would bring bagged garbage from the facility and place it in the green, wired, open wagon (referred to by facility staff as a "cart"). The cart stood next to the back door of the kitchen. M-A stated when the cart was full, maintenance and housekeeping took the cart to the dumpster and emptied it. | 21735 | | |

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| 21735 | Continued From page 14<br><br>During an interview on 2/25/15, at 1:06 p.m. M-A stated the facility had no garbage policy.<br><br>On 2/26/2015 at 4:33 a.m., the cover of the dumpster was again observed to be partially open. In an interview on 2/26/15 at 10:09 a.m., housekeeper (H)-A stated night staff brought garbage to the cart at the end of their shift. The housekeepers brought garbage out to the cart throughout the day. H-A stated housekeeping and maintenance transported garbage via the cart to the dumpster as needed throughout the day.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The maintenance director or designee could develop, review, and/or revise policies and procedures to ensure the proper storage and disposal of garbage is maintained.<br>The maintenance director or designee could educate all appropriate staff on the policies and procedures.<br>The maintenance director or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) Days | 21735 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. | 21805 | | |

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| 21805 | Continued From page 15<br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide for dignified toileting opportunities for 2 of 2 residents (R10, R21).<br><br>Findings include:<br><br>R10's face sheet indicated diagnoses that included anxiety and depression. Her Minimum Data Set (MDS) dated 1/15/15, indicated she had a Brief Interview for Mental Status (BIMS) score of 7 (severely impaired) and was occasionally incontinent, mostly at night. R10's care plan indicated that she required one person to assist with toileting or bed pan upon request. Staff was to check her during first and last rounds at night.<br><br>On 2/23/15, at 3:21 p.m. during interview R10 stated sometimes the staff was crabby. R10 further revealed staff had so much to do, "Maybe I'm a nuisance, I don't know." R10 stated she cried when they were crabby to her. R10 stated she didn't say anything because staff will say she was the crabby one.<br><br>R10 was interviewed again on 2/25/15 at 8:27 a.m. and repeated her statement that staff was crabby. She continued to state one "gal" made her cry. R10 stated, "I just turned my head and cried." R10 stated she didn't want to bother them anymore, but it's their job to be the night nurse. R10 continued, saying "they're tired" and "I talk a lot." R10 further explained she hated to "wake them" at night, but she can't control her bladder. R10 stated they gave her a bed pan, which she didn't like, but they're in a hurry.<br><br>Continuous observation of R10' on 2/26/15 from | 21805 | | |

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| 21805 | Continued From page 16<br><br>4:33 a.m. through 8:20 a.m. revealed that although staff entered the room, no staff asked or offered toileting services. At 7:27 a.m., Activity Director (AD)-A entered R10's room with the daily newspaper and turned off the call light. R10 stated that she wanted to get up for the day. AD-A stated the staff were busy but she could bring R10's breakfast. R10 agreed and AD-A left the room to get breakfast. AD-A returned with a breakfast tray at 7:34 a.m. When interviewed at 7:42 a.m. R10 stated her incontinence pad was wet but not cold. At 7:47 a.m., LPN-A entered R10's room and administered eye drops and a nutritional supplement then left the room. When asked about breakfast in bed, R10 replied that she was "getting used to it." She further explained, "they're so late, it's easier." She stated sometimes the "therapy lady" got her ready so she could have her breakfast in the dining room. R10 was interviewed again at 8:10 a.m. and repeated she was wet, but not cold; "I'm in bed, so I'm warm." NA-D entered the room at 8:30 a.m. to inform R10 she would get up soon, when she informed NA-D that she had a wet incontinence pad. At 8:34 a.m. NA-D returned and R10 stated "Oh boy am I wet." R10 also stated "Boy I've been laying there a long time." R10 then informed NA-D that she hadn't been toileted or checked on all night. At 8:41 a.m. when toileted, R10's brief was observed to be urine soaked with a strong odor. While NA-D was assisting R10 in the bathroom, the pad on the bed was felt to be damp. At 8:56 a.m., NA-D folded the pad and tucked it under R10's pillow. When asked to feel if it was wet, NA-D pulled it back out, stated it was dry and replaced it under the pillow.<br><br>R21 stated during interview on 2/24/15, at 8:37 a.m., that lately staff didn't treat her with respect | 21805 | | |

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| 21805 | Continued From page 17 | 21805 | | |

and dignity. R21 said she doesn't get to bed when she wants to. R21 stated staff come in and say she'll "simply have to wait." R21 also identified a "night girl" came in and informed her she could no longer go to the bathroom at night. R21 told staff she would have to wet the bed then, and she did. R21 stated she now used the bed pan as she was told she required too much assistance and staff can't do it anymore. R21 acknowledged she was "fine" with the bedpan.

R21's MDS dated 1/6/15, indicated a BIMS score of 10 (moderate cognitive impairment). The MDS indicated that she was occasionally incontinent (less than 7 episodes in a week) of bladder and was on a toileting program. R21's care plan identified a pattern of urinary incontinence in the early a.m. related to her urge to void and that she was at risk of more incontinence related to her need for assistance with toileting, her history of immobility and CVA (cerebral vascular accident). R21's current care plan directed the following approaches:
*Assist of two with a PAL stand (mechanical lift that provides standing assistance) to toilet as requested, and
*Offer assistance to toilet.
R21's care plan lacks evidence to support that it is her preference to always use a bed pan at night.

During interview on 2/25/15, at 1:36 p.m., R21 stated she got a bed pan at night. She said, "I'm used to that" and guessed that everyone did at night. R21 stated, "I don't think anyone gets to use the bathroom at night."

During an interview on 2/26/15, at 5:17 a.m., NA-C stated R21 was a two person transfer and for about two months staff used bed pans at night

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| 21805 | Continued From page 18<br>for residents who required a two person transfer, as "most are incontinent". NA-C stated R21 had the urge to urinate "about every 20 minutes" at night and required two people to transfer, so staff used the bed pan at night.<br><br>Upon interview on 2/26/15 at 1:11 p.m. the director of nursing (DON) explained that in a recent call light audit, R21 used her call light 198 times in 7 days. The DON stated that R21 had an urge to go, and sometime there is just a "teaspoon of urine," and it was actually a behavioral or anxiety issue. The DON stated R21 "wants to be a princess". The DON verified that for the last month they were using the bed pan at night for R21.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of social services or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained.<br>The director of social services or designee could educate all appropriate staff on the policies and procedures.<br>The director of social services or designee could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) Days | 21805 | | |