DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 6, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: October 5, 2023

Dear Administrator:

On November 22, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 6, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: 57E212

Dear Administrator:

On November 22, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 5, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: October 5, 2023

Dear Administrator:

On October 5, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 5, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by April 5, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 10/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/2/23 to 10/5/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/2/23 to 10/5/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited. H52586007C (MN93870) H52586009C (MN90854) H52586008C (MN93869) H52586005C (MN93868) H52586006C (MN93871) H52586010C (MN93871) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 10/05/2023

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	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 561	F: 561 It is Franciscan Health Center's	11/20/23

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 _____	C 10/05/2023

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 561	Continued From page 2 facility failed to honor individual preferences for early morning toileting for 1 of 4 residents (R7) reviewed for choices. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/9/23, indicated R7 was cognitively intact. R7's undated, Facesheet identified R7 had multiple sclerosis and major depression and a history of urinary tract infection. R7's care plan dated 8/17/23, directed staff to check and change R7's brief at 5:00 a.m. R7 had a history of urinary tract infections. During an interview on 10/2/23 at 1:27 p.m., R7 stated they repeatedly told staff they wanted staff to wake them up at 5:00 a.m., but it was not getting done. R7 shared this request with managers. If the night staff didn't get R7 up at 5:00 a.m. R7 usually had to wait until around 7:00 a.m. to get assistance to the bathroom. During an interview on 10/4/23 at 7:37 a.m., R7 reported they had woken up around 6:00 a.m. and had to call for staff to come in. R7 did not recall what time they got up on 10/3/23, but indicated no one woke R7 to use the bathroom at 5:00 a.m. During an interview on 10/5/23 at 1:34 a.m., R7 stated nobody woke them at 5:00 a.m. and R7 had to call for staff assistance when they woke up. R7 explained they wanted staff to get them up at 5:00 a.m. because they didn't want to have an incontinence episode. They were not concerned about the actual incontinence but were afraid of	F 561	policy to provide residents the right to choices in the care routine. Director of Nursing and/or designee will implement corrective action for resident R7 affected by this practice by: • R7 will have brief checked and changed at 0500 and Q2-3H PRN. • R7 care plan was reviewed on 10-18-2023 and currently reflects preference. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents with specific preferences outlined in the care plan have the potential to be affected by the same deficient practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • Education provided to staff on honoring resident preferences. Person centered policy reviewed with and copy given to direct care staff at CNA meeting held 10-12-2023. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying personal choices will be completed by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the	

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 _____	C 10/05/2023

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 561	Continued From page 3 getting a UTI from being in a wet brief while they waited their turn for help. During an interview on 10/5/23 at 11:54 a.m., registered nurse (RN)-B stated it was her expectation that staff would be getting R7 up at 5:00 a.m. each morning because that was R7's preference. R7's care plan was specifically updated to include a 5:00 a.m. wake time as that was R7's preference. During an interview on 10/5/23 at 2:07 p.m., the director of nursing (DON) stated if it was care planned for a resident to be woke up at 5:00 a.m., then they expected staff would be going in each morning at 5:00 a.m. to see if the resident wanted to get up. R7's request to be woken at 5:00 a.m. should be honored. The facility policy Person Centered Care Planning dated 3/7/22, indicated the care center would develop an individual plan of care which respected and identified individualized choices when determining daily care needs and activities. The policy indicated the facility would honor resident choices as long it was determined there was no risk associated with the choice.	F 561	QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling	F 568		11/20/23

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 _____	C 10/05/2023

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 568	Continued From page 4 of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents with trust accounts received quarterly statements for 1 of 1 residents (R7) reviewed for resident funds. This had the potential to affect 58 current and discharged residents who had personal accounts managed by the facility. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/9/23, indicated R7 was cognitively intact. During an interview on 10/2/23 at 1:12 p.m., R7 stated they never received statements from the facility for their personal trust account. During an interview on 10/4/23 at 3:13 p.m. the administrator confirmed resident trust account statements were not sent out since his start date of 1/3/23. The facility had 58 residents with a trust account at the facility. Residents and/or their representative should receive quarterly trust account statements. . The Trust Fund Monthly Summary, dated 10/4/23, identified there were 58 residents with current trust accounts at the facility; however, not all residents residing in the facility were identified to have a trust account. Trust account polices were requested, but not	F 568	F: 568 It is Franciscan Health Center's policy to provide residents/families statements of their trust fund accounts at least quarterly. Administrator and/or designee will implement corrective action for resident R7 affected by this practice by: • R7 was given a trust statement on 10/23/2023. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have trust fund accounts have the potential to be affected by deficient practice. • All residents/families with trust fund accounts had their trust fund statements delivered or mailed on 10/23/2023. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The Resident Trust Fund Account policy was reviewed. • The administrator was trained on the policy regarding providing trust fund statements at least quarterly. Administrator and/or designee will monitor corrective actions to ensure the	

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 _____	C 10/05/2023

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 568	Continued From page 5 received.	F 568	effectiveness of these actions including: • Audits identifying trust fund statements were provided to residents/families will be completed quarterly beginning in January 2024 for the 4th quarter of 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the surety bond was equal to or greater than the resident funds entrusted to the facility. This had the potential to affect all 58 current and discharged residents who had personal accounts managed by the facility. Findings include: The Bond Transaction Summary dated 10/1/23, identified the facility had a $25,000.00 surety bond that was issued by Nationwide Mutual Insurance company. The Trust Fund Monthly Summary dated 10/4/23, indicated the facility had 58 current/ discharged residents with trust fund accounts at the facility.	F 570	F: 570 It is Franciscan Health Center's policy to provide a surety bond large enough to cover the balance of resident's personal funds. Administrator and/or designee will implement corrective action for all residents affected by this practice by: • A surety bond was requested for $60,000.00 to cover the balance of the resident trust account for 10/01/2023. Administrator and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have trust fund accounts have the potential to be affected	11/20/23

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 _____	C 10/05/2023

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 570	Continued From page 6 The total balance of the trust accounts was listed as $44,433.61. During an interview on 10/4/23 at 3:13 p.m., the administrator stated the total trust account balance was $31,947.85 and the facility surety bond was for $25,000.00, which did not cover the current trust account balance made up of funds from 58 residents.	F 570	by deficient practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: • The administrator was trained on surety bond requirements and will ensure the surety bond covers the trust fund account balance. Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Specific audits regarding trust fund balance and surety bond amount will be conducted monthly by the administrator to ensure that the trust fund balance remains below the surety bond amount beginning the week of October 30, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636		11/20/23

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 _____	C 10/05/2023

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 636	Continued From page 7 resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.	F 636		

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 _____	C 10/05/2023

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 636	Continued From page 8 (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess psychotropic medications using the Resident Assessment Instrument (RAI) process for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's annual Minimum Data Set (MDS) dated 3/8/23, identified R26 had severe cognitive impairment. R26 received 7 days of antipsychotic and antidepressant medication during the Assessment Reference Date (ARD). Section V 0200 of the Care Area Assessment (CAA) and care planning, identified psychotropic drug use had triggered for completion. An undated, unlabeled document identified R26 started Seroquel 25 mg daily on 12/21/22, and listed anxiousness, restlessness and sleep as targeted behaviors for Seroquel. R26's Psychoactive Medication Informed Consent Form dated 5/30/22, indicated R26 was taking sertraline for the target behavior of decreased mood. R26's medical record lacked evidence CAA's had	F 636	F: 636 It is Franciscan Health Center's policy to assess residents on psychotropic medications. Director of Nursing and/or designee will implement corrective action for resident R26 affected by this practice by: • CAA's will be completed for R26 in when receiving 7 days of antipsychotic and antidepressant medication during the ARD period. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents receiving antipsychotic and/or antidepressant medications during the ARD period are at risk of triggering for a CAA's to be completed. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • Education provided to staff responsible that putting "refer to another assessment" is not acceptable documentation. CAA training provided to MDS coordinator.	

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 _____	C 10/05/2023

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 636	Continued From page 9 been completed for psychotropic medication. During an interview on 10/4/23 at 2:51 p.m., registered nurse (RN)-C confirmed R26 had received psychotropic medication during the ARD and stated the CAA for psychotropic medications was not completed. During an interview on 10/5/23 at 2:07 p.m., the director of nursing stated R26 did not have any CAA's completed for psychotropic medication because they had not triggered for completion. The MDS 3.0 RAI Manual dated 10/19, identified triggered CAA's were to be completed within 14 days following the completion of the ARD period.	F 636	Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of CAA documentation will be completed by the Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded to reflect restraint use for 3 of 3 residents (R10, R24, R38); and failed to include a diagnosis for 1 of 1 residents (R26) reviewed for MDS accuracy. Findings include: Restraints: R10: R10's quarterly Minimum Data Set (MDS) dated 8/16/23, indicated R10 was cognitively intact.	F 641	F: 641 It is Franciscan Health Center's policy to have accurate MDS coding. Director of Nursing and/or designee will implement corrective action for resident R10, R24 and R38 affected by this practice by: • Resident's R10, R24, and R38 MDS will be reviewed and accurately coded regarding mobility bars for assistance with bed mobility and not as restraints. • R26 has dx of unspecified dementia w/o behavioral disturbances (F03.90) included on diagnosis list and moved to	11/20/23

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 _____	C 10/05/2023

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 641	Continued From page 10 MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. On 10/3/23 at 2:12 p.m., R10 was in bed. The bed had a hand rail on each side of the bed. R10 stated the bed rails helped them move around in bed. R24: R24's quarterly MDS dated 8/16/23, indicated R24 had severe cognitive impairment. MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. During an observation on 10/2/23 at 2:27 p,m., R24 was in bed. R24's bed had two quarter side rails on the bed in upright potion. During an interview on 10/4/23 at 1:35 p.m., nursing assistant (NA)-E stated R24 had bedrails, so R24 could participate in bed mobility. Staff did most of the work, but R24 usually grabbed onto the bed when being repositioned on to their side. R38: R38's admission MDS dated 8/2/23, indicated R38 was cognitively intact. MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. During an observation on 10/5/23 at 11:32 a.m., R38 was not in their room. R38's bed had a hand rail attached to the left side of the bed. During an interview on 10/5/23 at 1:54 p.m., trained medication aide (TMA)-A stated R38 used the hand rail to assist with transfers and bed mobility.	F 641	R24's active diagnosis. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have mobility rails for turning and repositioning have the potential to be affected by this practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • Education provided to RN Managers to complete the Mobility Rail assessment prior to first use, annually, and with any significant change in condition. • The Restraints/Devices section of the MDS General Observations regarding bed rails will no longer be used for residents with mobility bars. • Resident's diagnosis list will be reviewed by MD during routine visits to add/delete any diagnosis. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of current MDS assessments including mobility rails be completed by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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 _____	C 10/05/2023

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 641	Continued From page 11 During an interview on 10/4/23 at 2:47 p.m., registered nurse (RN)-C stated the facility had not used restraints on any residents in the facility. Side rails and hand rails were used for mobility and were not considered restraints. RN-C was not aware of why the rails were coded as restraints. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/19, outlined a section labeled, "SECTION P: RESTRAINTS AND ALARMS," which directed to record the frequency a resident was restrained by any of the listed devices during the seven day look-back period. A definition of physical restraint was provided which outlined, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Diagnosis: R26: R26's quarterly MDS dated 8/30/23, indicated R26 had severe cognitive impairment. MDS section I did not include a diagnosis of dementia. R26's undated, Facesheet included a diagnosis of dementia. During an interview on 10/4/23 at 2:51 p.m., registered nurse (RN)-C stated dementia should have been coded for R26. The MDS 3.0 Assessment policy dated 10/13/21, indicated the facility would conduct an accurate	F 641	Completion Date: November 20, 2023	

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 _____	C 10/05/2023

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 641	Continued From page 12 and standardized assessment of each resident using the RAI and indicated the MDS coordinator coding responsibilities included section I and P0100.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform activities of daily living (ADL's) for 1 of 6 residents (R24) reviewed for ADL's. Findings include: R24's quarterly Minimum Data Set (MDS) dated 8/16/23, identified R24 had severe cognitive impairment and required extensive physical assistance of one person personal hygiene. Diagnoses included progressive neurological decline and non-Alzheimer's dementia. R24's care plan dated 9/7/23, instructed staff to shave R24's face daily. During an observation on 10/2/23 at 2:27 p.m., R27 had whisker stubble along the sides of his face, chin, and upper lip. During an observation on 10/3/23 at 12:44 p.m., R27 continued to have whisker stubble along the sides of his face, chin, and upper lip.	F 677	F: 677 It is Franciscan Health Center's policy to provide ADL care for dependent residents per our resident's plan of care. Director of Nursing and/or designee will implement corrective action for resident R24 affected by this practice by: • R24 will be shaved daily. • R24's care plan reviewed on 10/19/23, currently reflects to be shaved daily and is assigned to each shift. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are dependent on staff for shaving have the potential to be affected by deficient practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • Education provided to staff on reviewing care plan/care stream for assigned tasks on CNA meeting held 10-	11/20/23

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 _____	C 10/05/2023

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 677	Continued From page 13 During an observation on 10/3/23 at 4:00 p.m., R27 continued to have whisker stubble on his face, his hair was wet and combed back. During an observation on 10/4/23 at 11:01 a.m., R27 was located in the dining room seated in a wheelchair, dressed, glasses on, with noticeable whisker stubble. During an observation on 10/5/23 at 11:35 a.m., R27 was dressed with glasses on. R27 continued to have whisker stubble on the sides of his face, upper lip and chin. During an interview on 10/4/23 at 1:35 p.m., nursing assistant (NA)-E stated R27 was not shaved, but they believed he was normally shaved every day. NA-E stated a therapist was shaving residents later that afternoon so R27 might get shaved by the therapist later. During an interview on 10/5/23 at 12:14 p.m., registered nurse (RN)-A stated they would expect staff to shave R27 daily because that was their preference. During an interview on 10/5/23 at 2:09 p.m., the director of nursing stated (DON) if it was care planned for R27 to be shaved daily then R27 should be shaved daily. If the NA's are not able to shave R27, that should be reported to the nurse manager for documentation. R27 had more than a days worth of whisker growth.	F 677	12-2023. Person centered policy reviewed and copies given to staff during meeting. • All residents who need assistance with toileting will have their care plan reviewed and updated as needed. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying shaving per resident's care plan will be completed by Director of Nursing/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		11/20/23

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 _____	C 10/05/2023

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 695	Continued From page 14 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oxygen tubing was changed according to policy for 1 of 1 residents (R10) reviewed for respiratory care. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/16/23, indicated R10 was cognitively intact. Diagnoses included end stage renal disease and chronic respiratory failure. R10's undated Resident Face Sheet, included an order for oxygen 1 liter per minute to keep oxygen levels above 90 percent three times daily, there was no order for oxygen tubing to be changed weekly. R10's care plan dated 8/16/23, instructed the use of oxygen for comfort care. During an observation on 10/2/23 at 2:49 p.m., R10 was in bed wearing nasal cannula oxygen tubing with oxygen running. The tubing was connected to a large oxygen concentrator in the room. There was not a visible change date on R10's oxygen tubing. During an observation on 10/3/23 at 1:30 p.m., R10 was in bed with nasal cannula on and	F 695	F: 695 It is Franciscan Health Center's policy to change oxygen tubing as needed and at least weekly. Director of Nursing and/or designee will implement corrective action for resident R10 affected by this practice by: · R10's oxygen tubing was changed on 10/5/2023. · An order was placed in the Emar for tubing to be changed weekly-Sunday-during NOC shift. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents receiving oxygen are at risk for not having the tubing changed weekly per facility policy. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • All residents with oxygen use had orders reviewed to ensure an order was in place to change tubing weekly per policy. Orders were obtained and entered for residents without active orders to change tubing weekly. • Education provider to current NOC	

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 _____	C 10/05/2023

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 695	Continued From page 15 oxygen running. During an observation on 10/04/23 at 8:26 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. On 10/5/23 at 11:45 a.m., registered nurse (RN)-B stated it was the cart nurse's responsibility to ensure oxygen tubing was dated and changed once a week. There was not a weekly oxygen tubing change ordered for R10, and explained the order should be in place because that was how the due date showed up on the medication administration record (MAR). RN-B entered R10's room and located a sticker on the oxygen tubing dated 9/25/23. RN-B stated R10's oxygen tubing change was overdue and the tubing needed to be changed to ensure adequate airflow and to prevent infection. During an interview on 10/5/23 at 2:11 p.m., the director of nursing (DON) stated all residents with oxygen should have a weekly tubing change ordered. A task was assigned each night with a list of who needs the task completed, so oxygen tubing should have been changed for R10 even without a nursing order. The DON expected an order for tubing change to be obtained, oxygen tubing to be labeled and dated, and changed at minimum, once a week. This was important for preventing infection and to ensure residents had functioning tubing. The facility policy Oxygen Concentrator dated 10/22, directed staff to change nasal cannula	F 695	shift staff regarding nightly duties assigned to them and a copy of NOC nurse task list printed and posted in med room. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying oxygen tubing being changed will be completed by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	

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 _____	C 10/05/2023

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 695	Continued From page 16 tubing once a week unless needed more frequently.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement anticoagulant side-effect monitoring for 1 of 2 resident (R12) reviewed for anticoagulant use. Findings include: R12's quarterly Minimum Data Set (MDS) dated 9/27/23, identified diagnoses of hypertension and	F 757	F: 757 It is Franciscan Health Center's policy to provide monitoring for residents on anticoagulation therapy per our resident's plan of care. Director of Nursing and/or designee will implement corrective action for resident R12 affected by this practice by: · R12's Care Plan was reviewed and	11/20/23

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 _____	C 10/05/2023

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 757	Continued From page 17 peripheral vascular disease or peripheral arterial disease. R12 was cognitively intact and an anticoagulant was used during the last seven days prior to the completion of the MDS. R12's current provider orders dated 3/4/22, directed staff to administer Xarelto (a blood thinner that can only be monitored by observation) 20 milligrams (mg) daily. R12's care plan dated 5/25/22, failed to identify R12's interventions related to anticoagulant use or that R12 was on anticoagulant. During interview on 10/5/23 at 11:13 a.m., nursing assistant (NA)-A stated the nursing assistants refer to electronic medical record to know how to care for and monitor each resident. There was nobody on NA-A's unit that was on a blood thinner and needed closer monitoring. NA-A reviewed R12's medical record that nurse assistants had access to and indicated R12 was not on blood thinners. During interview on 10/5/23 at 11:53 a.m., registered nurse (RN)-A stated R12 was on Xarelto based on the medication orders. No where else on the electronic medical record indicated R12 was on blood thinners so no other staff would be aware close monitoring for bleeding/bruising was needed. During interview on 10/5/23 at 11:59 a.m., the director of nursing (DON) stated there should be a nursing order placed to monitor for anticoagulant side effects such as bleeding and bruising. There should also be an intervention in the care plan so all staff that work with R12 are aware of the increased risk of bleeding and	F 757	updated as necessary to reflect appropriate anticoagulant use and orders for monitoring every shift on 10/06/2023. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents who are on anticoagulants have the potential to be affected by this deficient practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • An anticoagulant use policy will be created and updated as needed. • All residents who receive anticoagulants had their care plans reviewed to assure that accurate information is in place to reflect anticoagulant use. Updates will be made as needed. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying that monitoring is in place and resident care plan reflects anticoagulant use will be completed by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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 _____	C 10/05/2023

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 757	Continued From page 18 bruising. All staff were expected to monitor for bleeding to keep the resident safe. A policy for anticoagulant monitoring was requested but not provided.	F 757	Completion Date: November 20, 2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		11/20/23

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 _____	C 10/05/2023

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 758	Continued From page 19 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed provide evidence of non-pharmalogical interventions prior to the admininistration of as-needed (PRN) psychotropic medications and identify behavior monitoring for 1 of 5 residents (R34); and failed to identify behavior and side effect monitoring 1 of 5 (R26) residents reviewed for unnecessary medication use. Findings include: R34's significant change Minimum Data Set (MDS) dated 8/4/23, identified diagnoses of dementia and Parkinson's disease. R34 was cognitively intact and had behaviors of rejection of cares. The cooresponding Care Area Assessment (CAA) dated 8/4/23, identified specific areas to address were behavioral symptoms and psychotropic drug use.	F 758	F: 758 It is Franciscan Health Center's policy to provide residents with appropriate medications, monitoring, and non-pharmacological interventions. Director of Nursing and/or designee will implement corrective action for resident R26 and R34 affected by this practice by: · R26 care plan updated on 10/6/2023 to include monitoring for therapeutic effects of and side effects of prescribed antipsychotic medications and specific behaviors that indicate its use. · R26 had an AIMS assessment completed on 10/23/2023 and will be completed semiannually and PRN. · R34 passed away on 10/04/2023. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including:	

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 _____	C 10/05/2023

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 758	Continued From page 20 R34's care plan dated 11/2/22, indicated a care plan for mental health behaviors was initiated but lacked goals and interventions staff would try to assist the resident back to baseline. R34's Doctor's Orders form dated 8/17/23, directed staff to administer Alprazolam oral tablet 0.5 milligram (mg) tablet by mouth every 4 hours as needed for panic attack or restlessness. The orders lacked non-pharmolocical interventions to use prior to administering as needed antipsychotic medications. R34's electronic medication administration record (EMAR) dated 9/1/23 to 9/30/23, indicated R34 received Alprazolam on 9/17/23, and 9/23/23, for "anxiety" with follow up documentation of "effective." The medical record lacked evidence of symptoms exhibited or non-pharmological interventions attempted prior to medications to indicated the medication was needed. During an interview on 10/5/23 at 11:53 a.m., registered nurse (RN)-A stated prior to giving a PRN antipsychotic medication there were non-pharmacological behavioral interventions that needed to be attempted and documented prior to medications being given. RN-A reviewed the EMAR and the progress notes and stated there was no evidence of any attempts to address prior to the medication given. There should be interventions such as distraction, repositioning or 1 on 1 activities performed. During an interview on 10/5/23 at 11:59 a.m. the director of nursing (DON) reviewed R34's EMAR and progress notes and stated there was no documentation of non-pharmalogical interventions or the symptoms exhibited when the	F 758	• All residents who are on antipsychotics have the potential to be affected by this deficient practice. Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • All residents taking any antipsychotic medications will be assessed using the AIMS scale by 11/03/2023, if needed, and semiannually thereafter. • All residents who receive antipsychotics had their care plans reviewed to include target behaviors, non-pharmacological interventions, and potential side effects of medications. Updates will be made as needed. • Emar orders will be entered to monitor daily for behaviors and side effects of psychotropic medications. • Nurse Managers will be educated on the use of antipsychotics and monitoring of target behaviors, non-pharmacological interventions, and potential side effects of medications. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying that monitoring is in place and resident care plan reflects antipsychotic use will be completed by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the	

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 _____	C 10/05/2023

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 758	Continued From page 21 PRN antipsychotic medication was given. DON expected nursing would document non-pharmacological interventions and symptom management prior to antipsychotic medication being given. Nursing would then document the change that occurred after medication was given. R26's quarterly MDS dated 8/30/23, identifed R26 had severe cognitive impairment and was receiving an antipsychotic medication. R26's undated, facesheet included diagnoses of major depressive disorder, dementia, and delusional disorders. R26's undated Physician Order Review included an order for Seroquel 25 milligrams (mg) daily at bedtime. R26' care plan dated 7/17/23, did not instruct staff to monitor R26 for therapeutic effects of or side effects from prescribed antipsychotic medication, nor did it identify what behaviors seroquel was prescribed for and the facility was monitoring for. R26's medical record lacked evidence R26 had been monitored for antipsychotic medication side effects, including an Abnormal Involuntary Assessment (AIMS) (assessment to monitor for side effects of an antipsychotic medication) During an interview on 10/5/23 at 11:56 a.m., RN-B stated at risk medications should be put on the care plan. Behavior monitoring should be completed for residents on antipsychotics to see if the medication was working or if the dose needed to be changed. The facility did not complete daily charting on behaviors or side	F 758	QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	

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 _____	C 10/05/2023

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 758	Continued From page 22 effects, but they did have the ability to trigger frequent documentation if needed. During an interview on 10/5/23 at 12:10 a.m., RN-A stated residents should be monitored for antipsychotic medication. The facility completed AIMS two times a year on residents with prescribed antipsychotic medication; however, R26 did not have a completed AIMS. R26's care plan should have included behavior monitoring for therapeutic effect and side effect monitoring for antipsychotic medication, but it did not. During an interview on 10/5/23 at 2:00 p.m., DON stated routine AIMS assessments should be completed on all residents that received antipsychotic medication. R26's electronic medication administration record and/or careplan should have included direction for side effect and behavior monitoring for antipsychotic medication. The Psychotropic Medications policy dated 9/11/23, indicated: psychotropic drug should be monitored daily and included targeted behaviors and adverse side effects. Specific target behaviors should be included on the careplan. A DISCUS or AIMS should be completed at least every 6 months. The policy failed to identify the PRN medication use procedure.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		11/20/23

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 _____	C 10/05/2023

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 880	Continued From page 23 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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 _____	C 10/05/2023

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 880	Continued From page 24 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident lifts were effectively sanitize prior to being used on other residents for 3 of 3 residents (R18, R31, R37) observed during lift transfers. Findings include: During observation on 10/2/23 at 2:18 p.m., certified occupational therapy assistant (COTA)-D entered R18's room, transferred R18 with the assist to stand, R18 physically touched the lift. After the transfer COTA-D took the lift back to the hallway without sanitizing the lift. During observation on 10/2/23 at 2:31 p.m., nurse assistant (NA)-B gathered the unsanitized assist to stand lift, entered R31's room, and transferred	F 880	F: 880 It is Franciscan Health Center's policy to use proper sanitation of mechanical lifts between resident use. Director of Nursing and/or designee will implement corrective action for resident R7, R18, R31 affected by this practice by: • Staff caring for residents R7, R18, and R31 will use proper sanitation techniques on mechanical lifts. Director of Nursing and/or designee will assess residents having the potential to be affected by this practice including: • All residents transferred with mechanical lifts have the potential to be affected by deficient practice.	

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 _____	C 10/05/2023

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 880	Continued From page 25 R31 from the chair to commode and back without sanitizing the lift. NA-B exited the room without sanitizing the lift. As NA-B was exiting the room NA-C grabbed the lift without it being sanitized and entered R37's room. NA-C used the lift to transfer R37 to the bed, and returned the unsanitized lift to the hallway without sanitizing it. During observation on 10/2/23 at 2:41 p.m., NA-D gathered the unsanitized lift and entered R31's room to transfer R31 out of the chair and get R31 ready for lunch. As NA-D was getting R31 connected to the lift NA-D. The surveyor intervened and asked NA-D to step out of the room with the lift and then asked to sanitize the lift. During an interview 10/2/23 at 3:14 p.m., COTA-D stated the lift was not sanitized before or after using it on R18, and prior to putting it in the hallway. During an interview 10/2/23 at 3:31 p.m., NA-D stated the lift is supposed to be sanitized after each use, so it was ready for the next person that needed to use it. During an interview 10/2/23 at 3: 36 p.m., NA-C stated he did not clean the lift prior to use because the staff that used it before NA-C should have sanitized it. NA-C acknowledged he had not sanitized the lift after he used it. During an interview on 10/4/23 at 2:02 p.m., the infection preventionist (IP) stated all resident lifts should be sanitized at least after each use. If the lifts were not sanitized after each use, there would be an increased risk of spreading bacteria and cross contamination leading to resident	F 880	Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including: • All DME was disinfected throughout the facility by staff the week of 10/09/2023. • Disinfecting wipes were placed in the pocket of each mechanical lift if there were none present. • Education provided to staff on disinfecting DME between residents. Disinfection and Resident care equipment was reviewed with, and copy given to direct care staff at CNA meeting held 10-12-2023. Knowledge as to where cleaning product is located and instructions for its use reviewed. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying cleaning of DME between resident use will be completed by Director of Nursing/designee 5x/week x 1 week, 3x/week x 2 weeks, then once weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023	

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 _____	C 10/05/2023

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 880	Continued From page 26 illnesses. The IP reviewed R18's, R31's and R37's chart and confirmed none of the residents had current communicable diseases. During an interview on 10/4/23 at 2:28 p.m. the director of nursing (DON) stated their expectation was all staff observe accurate infection control practices when using lifts to protect all residents from illness. The facility policy Disinfection of Resident Care Equipment dated 3/22/17, identified durable medical equipment would be cleaned and disinfected between residents.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: 57E211

Dear Administrator:

The above facility was surveyed on October 2, 2023 through October 5, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 10/05/2023

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 10/2/23 to 10/5/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey and no licensing orders were issued: H52586007C (MN93870) H52586009C (MN90854) H52586008C (MN93869) H52586005C (MN93868) H52586006C (MN93871) H52586010C (MN93871) 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 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each	2 540		11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
2 540	Continued From page 3 resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess psychotropic medications using the Resident Assessment Instrument (RAI) process for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include:	2 540	Corrected	

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 _____	C 10/05/2023

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) COMPLETE DATE
2 540	Continued From page 4 R26's annual Minimum Data Set (MDS) dated 3/8/23, identified R26 had severe cognitive impairment. R26 received 7 days of antipsychotic and antidepressant medication during the Assessment Reference Date (ARD). Section V 0200 of the Care Area Assessment (CAA) and care planning, identified psychotropic drug use had triggered for completion. An undated, unlabeled document identified R26 started Seroquel 25 mg daily on 12/21/22, and listed anxiousness, restlessness and sleep as targeted behaviors for Seroquel. R26's Psychoactive Medication Informed Consent Form dated 5/30/22, indicated R26 was taking sertraline for the target behavior of decreased mood. R26's medical record lacked evidence CAA's had been completed for psychotropic medication. During an interview on 10/4/23 at 2:51 p.m., registered nurse (RN)-C confirmed R26 had received psychotropic medication during the ARD and stated the CAA for psychotropic medications was not completed. During an interview on 10/5/23 at 2:07 p.m., the director of nursing (DON) stated R26 did not have any CAA's completed for psychotropic medication because they had not triggered for completion. The MDS 3.0 RAI Manual dated 10/19, identified triggered CAA's were to be completed within 14 days following the completion of the ARD period. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise	2 540		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 540	Continued From page 5 policies and procedures related to performing Minimum Data Set (MDS) and the collection of required information; and educate staff to policy or procedure changes ; and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded to reflect restraint use for 3 of 3 residents (R10, R24, R38); and failed to include a diagnosis for 1 of 1 residents (R26) reviewed for MDS accuracy. Findings include: Restraints: R10: R10's quarterly Minimum Data Set (MDS) dated 8/16/23, indicated R10 was cognitively intact.	2 550	Corrected	11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
2 550	Continued From page 6 MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. On 10/3/23 at 2:12 p.m., R10 was in bed. The bed had a hand rail on each side of the bed. R10 stated the bed rails helped them move around in bed. R24: R24's quarterly MDS dated 8/16/23, indicated R24 had severe cognitive impairment. MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. During an observation on 10/2/23 at 2:27 p,m., R24 was in bed. R24's bed had two quarter side rails on the bed in upright potion. During an interview on 10/4/23 at 1:35 p.m., nursing assistant (NA)-E stated R24 had bedrails, so R24 could participate in bed mobility. Staff did most of the work, but R24 usually grabbed onto the bed when being repositioned on to their side. R38: R38's admission MDS dated 8/2/23, indicated R38 was cognitively intact. MDS section P0100 Physical Restraints, A. bed rail, was marked daily use. During an observation on 10/5/23 at 11:32 a.m., R38 was not in their room. R38's bed had a hand rail attached to the left side of the bed. During an interview on 10/5/23 at 1:54 p.m., trained medication aide (TMA)-A stated R38 used the hand rail to assist with transfers and bed mobility. During an interview on 10/4/23 at 2:47 p.m.,	2 550		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 550	Continued From page 7 registered nurse (RN)-C stated the facility had not used restraints on any residents in the facility. Side rails and hand rails were used for mobility and were not considered restraints. RN-C was not aware of why the rails were coded as restraints. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/19, outlined a section labeled, "SECTION P: RESTRAINTS AND ALARMS," which directed to record the frequency a resident was restrained by any of the listed devices during the seven day look-back period. A definition of physical restraint was provided which outlined, "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body." Diagnosis: R26: R26's quarterly MDS dated 8/30/23, indicated R26 had severe cognitive impairment. MDS section I did not include a diagnosis of dementia. R26's undated, Facesheet included a diagnosis of dementia. During an interview on 10/4/23 at 2:51 p.m., registered nurse (RN)-C stated dementia should have been coded for R26. The MDS 3.0 Assessment policy dated 10/13/21, indicated the facility would conduct an accurate and standardized assessment of each resident using the RAI and indicated the MDS coordinator	2 550		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 550	Continued From page 8 coding responsibilities included section I and P0100. SUGGESTED METHOD OF CORRECTION: The director nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) and the collection of required information; and educate staff to policy or procedure changes ; and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform activities of daily living (ADL's) for 1 of 6 residents (R24) reviewed for ADL's. Findings include:	2 920	Corrected	11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
2 920	Continued From page 9 R24's quarterly Minimum Data Set (MDS) dated 8/16/23, identified R24 had severe cognitive impairment and required extensive physical assistance of one person personal hygiene. Diagnoses included progressive neurological decline and non-Alzheimer's dementia. R24's care plan dated 9/7/23, instructed staff to shave R24's face daily. During an observation on 10/2/23 at 2:27 p.m., R27 had whisker stubble along the sides of his face, chin, and upper lip. During an observation on 10/3/23 at 12:44 p.m., R27 continued to have whisker stubble along the sides of his face, chin, and upper lip. During an observation on 10/3/23 at 4:00 p.m., R27 continued to have whisker stubble on his face, his hair was wet and combed back. During an observation on 10/4/23 at 11:01 a.m., R27 was located in the dining room seated in a wheelchair, dressed, glasses on, with noticeable whisker stubble. During an observation on 10/5/23 at 11:35 a.m., R27 was dressed with glasses on. R27 continued to have whisker stubble on the sides of his face, upper lip and chin. During an interview on 10/4/23 at 1:35 p.m., nursing assistant (NA)-E stated R27 was not shaved, but they believed he was normally shaved every day. NA-E stated a therapist was shaving residents later that afternoon so R27 might get shaved by the therapist later. During an interview on 10/5/23 at 12:14 p.m.,	2 920		

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 _____	C 10/05/2023

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) COMPLETE DATE
2 920	Continued From page 10 registered nurse (RN)-A stated they would expect staff to shave R27 daily because that was their preference. During an interview on 10/5/23 at 2:09 p.m., the director of nursing stated (DON) if it was care planned for R27 to be shaved daily then R27 should be shaved daily. If the NA's are not able to shave R27, that should be reported to the nurse manager for documentation. R27 had more than a days worth of whisker growth. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit resident care who are dependent on staff and educate responsible staff based on the assessed and care plan needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident lifts were effectively sanitize prior to being used on other residents for 3 of 3 residents (R18, R31,	21375	Corrected	11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
21375	Continued From page 11 R37) observed during lift transfers. Findings include: During observation on 10/2/23 at 2:18 p.m., certified occupational therapy assistant (COTA)-D entered R18's room, transferred R18 with the assist to stand, R18 physically touched the lift. After the transfer COTA-D took the lift back to the hallway without sanitizing the lift. During observation on 10/2/23 at 2:31 p.m., nurse assistant (NA)-B gathered the unsanitized assist to stand lift, entered R31's room, and transferred R31 from the chair to commode and back without sanitizing the lift. NA-B exited the room without sanitizing the lift. As NA-B was exiting the room NA-C grabbed the lift without it being sanitized and entered R37's room. NA-C used the lift to transfer R37 to the bed, and returned the unsanitized lift to the hallway without sanitizing it. During observation on 10/2/23 at 2:41 p.m., NA-D gathered the unsanitized lift and entered R31's room to transfer R31 out of the chair and get R31 ready for lunch. As NA-D was getting R31 connected to the lift NA-D. The surveyor intervened and asked NA-D to step out of the room with the lift and then asked to sanitize the lift. During an interview 10/2/23 at 3:14 p.m., COTA-D stated the lift was not sanitized before or after using it on R18, and prior to putting it in the hallway. During an interview 10/2/23 at 3:31 p.m., NA-D stated the lift is supposed to be sanitized after each use, so it was ready for the next person that needed to use it.	21375		

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 _____	C 10/05/2023

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) COMPLETE DATE
21375	Continued From page 12 During an interview 10/2/23 at 3: 36 p.m., NA-C stated he did not clean the lift prior to use because the staff that used it before NA-C should have sanitized it. NA-C acknowledged he had not sanitized the lift after he used it. During an interview on 10/4/23 at 2:02 p.m., the infection preventionist (IP) stated all resident lifts should be sanitized at least after each use. If the lifts were not sanitized after each use, there would be an increased risk of spreading bacteria and cross contamination leading to resident illnesses. The IP reviewed R18's, R31's and R37's chart and confirmed none of the residents had current communicable diseases. During an interview on 10/4/23 at 2:28 p.m. the director of nursing (DON) stated their expectation was all staff observe accurate infection control practices when using lifts to protect all residents from illness. The facility policy Disinfection of Resident Care Equipment dated 3/22/17, identified durable medical equipment would be cleaned and disinfected between residents. Suggested Method of Correction: The DON or designee could review/revise facility policies related to equiptment sanitization, educate staff and perform audits to ensure compliaince. Time Period for Correction: Twenty-one (21) days.	21375		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
21535	Continued From page 13 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement anticoagulant side-effect monitoring for 1 of 2 resident (R12) reviewed for anticoagulant use. Findings include: R12's quarterly Minimum Data Set (MDS) dated 9/27/23, identified diagnoses of hypertension and peripheral vascular disease or peripheral arterial disease. R12 was cognitively intact and an anticoagulant was used during the last seven days prior to the completion of the MDS.	21535	Corrected	

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 _____	C 10/05/2023

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) COMPLETE DATE
21535	Continued From page 14 R12's current provider orders dated 3/4/22, directed staff to administer Xarelto (a blood thinner that can only be monitored by observation) 20 milligrams (mg) daily. R12's care plan dated 5/25/22, failed to identify R12's interventions related to anticoagulant use or that R12 was on anticoagulant. During interview on 10/5/23 at 11:13 a.m., nursing assistant (NA)-A stated the nursing assistants refer to electronic medical record to know how to care for and monitor each resident. There was nobody on NA-A's unit that was on a blood thinner and needed closer monitoring. NA-A reviewed R12's medical record that nurse assistants had access to and indicated R12 was not on blood thinners. During interview on 10/5/23 at 11:53 a.m., registered nurse (RN)-A stated R12 was on Xarelto based on the medication orders. No where else on the electronic medical record indicated R12 was on blood thinners so no other staff would be aware close monitoring for bleeding/bruising was needed. During interview on 10/5/23 at 11:59 a.m., the director of nursing (DON) stated there should be a nursing order placed to monitor for anticoagulant side effects such as bleeding and bruising. There should also be an intervention in the care plan so all staff that work with R12 are aware of the increased risk of bleeding and bruising. All staff were expected to monitor for bleeding to keep the resident safe. A policy for anticoagulant monitoring was requested but not provided.	21535		

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 _____	C 10/05/2023

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) COMPLETE DATE
21535	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The DON or designee could develop and/or revise policies to include diagnoses, monitoring for behaviors/side effects, non-pharmacological intervention for scheduled and as needed medications; educate staff on the expectation and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason	21830		11/20/23

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 _____	C 10/05/2023

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) COMPLETE DATE
21830	Continued From page 16 to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident	21830		

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 _____	C 10/05/2023

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) COMPLETE DATE
21830	Continued From page 17 and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to honor individual preferences for early morning toileting for 1 of 4 residents (R7) reviewed for choices. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/9/23, indicated R7 was cognitively intact. R7's undated, Facesheet identified R7 had multiple sclerosis and major depression and a history of urinary tract infection. R7's care plan dated 8/17/23, directed staff to	21830	Corrected	

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 _____	C 10/05/2023

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) COMPLETE DATE
21830	Continued From page 18 check and change R7's brief at 5:00 a.m. R7 had a history of urinary tract infections. During an interview on 10/2/23 at 1:27 p.m., R7 stated they repeatedly told staff they wanted staff to wake them up at 5:00 a.m., but it was not getting done. R7 shared this request with managers. If the night staff didn't get R7 up at 5:00 a.m. R7 usually had to wait until around 7:00 a.m. to get assistance to the bathroom. During an interview on 10/4/23 at 7:37 a.m., R7 reported they had woken up around 6:00 a.m. and had to call for staff to come in. R7 did not recall what time they got up on 10/3/23, but indicated no one woke R7 to use the bathroom at 5:00 a.m. During an interview on 10/5/23 at 1:34 a.m., R7 stated nobody woke them at 5:00 a.m. and R7 had to call for staff assistance when they woke up. R7 explained they wanted staff to get them up at 5:00 a.m. because they didn't want to have an incontinence episode. They were not concerned about the actual incontinence but were afraid of getting a UTI from being in a wet brief while they waited their turn for help. During an interview on 10/5/23 at 11:54 a.m., registered nurse (RN)-B stated it was her expectation that staff would be getting R7 up at 5:00 a.m. each morning because that was R7's preference. R7's care plan was specifically updated to include a 5:00 a.m. wake time as that was R7's preference. During an interview on 10/5/23 at 2:07 p.m., the director of nursing (DON) stated if it was care planned for a resident to be woke up at 5:00 a.m., then they expected staff would be going in each	21830		

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 _____	C 10/05/2023

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) COMPLETE DATE
21830	Continued From page 19 morning at 5:00 a.m. to see if the resident wanted to get up. R7's request to be woken at 5:00 a.m. should be honored. The facility policy Person Centered Care Planning dated 3/7/22, indicated the care center would develop an individual plan of care which respected and identified individualized choices when determining daily care needs and activities. The policy indicated the facility would honor resident choices as long it was determined there was no risk associated with the choice. SUGGESTED METHOD OF CORRECTION: The social worker and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		