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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PH3B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00865

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle McFarland, HFE NEII 03/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5258

On March 12, 2014 a Post Certification Revisit was completed and verfiied correction of deficiencies issued pursuant to the January 16, 2014 standard survey, effective February 21, 2014. Refer to the CMS 2567b for the results of this visit.

Effective February 21, 2014, the facility is certified for 44 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5258

May 15, 2014

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

Dear Ms. Degrio:

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

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

Effective April 2, 2014 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,
Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900 Telephone
#: (651)201-4118
Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2014

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

RE: Project Number S5258023

Dear Ms. Degrio:

On February 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 16, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 16, 2014, effective February 21, 2014 and therefore remedies outlined in our letter to you dated February 24, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K55 at the time of the January 16, 2014 standard survey has been forwarded to CMS for their review and determination.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File
5258r14.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245258	A. Building B. Wing	3/12/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **02/21/2014**	ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **02/21/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/21/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/21/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/21/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/21/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/21/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/21/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/21/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PH	03/30/2014	00865	03/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/16/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PH3B

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245258**
2.STATE VENDOR OR MEDICAID NO.
(L2) **551218200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/16/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Ament, HFE NE II 2/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 3/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
PDF to ROCHI waiver K55 ____03/20/2014 CO.
Posted 03/20/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number:
Item 16 Continuation for CMS-1539

At the time of the standard survey completed January 16, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. The facility's request for a continuing waiver involving the deficiency cited at K55 is recommended for approval. Documentation supporting the waiver request is attached. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8385

January 31, 2014

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

RE: Project Number S5258023

Dear Ms. Degrio:

On January 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802
Telephone: (218) 723-4637
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 25, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 16, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 16, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance.

This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	01/16/2014

RECEIVED
FEB 12 2014
MN Dept of Health
Duluth

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	OK 2.12.14 PLH	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bathing preference frequency was honored for 1 of 3 residents (R52) who were reviewed for choices. Findings include: R52 preferred taking a shower every other week and this choice was not honored by the facility.	F 242		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah DeLuca | TITLE: Administrator | (X6) DATE: 2-12-2014

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 _____	01/16/2014

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 242	Continued From page 1	F 242	F242	

R52's Face Sheet dated 1/6/14, indicated R52's diagnoses included a stroke, pulmonary insufficiency, and anemia. R52's Minimum Data Set (MDS) dated 1/16/14, indicated R52 was cognitively intact, and required limited assistance with personal hygiene and physical help in part of bathing.

When interviewed on 1/13/14, at 2:50 p.m. R52 stated had lung problems and anemia, which made it difficult to take a shower every week, due to extreme fatigue and shortness of breath. R52 was use to taking a shower every other week prior to admission to the nursing home. R52 went on to say a nurse manager had met with her and a family member to discuss the issue, and had pressured R52 into agreeing to a weekly shower due to skin problems. However, R52 continued to only want a shower every other week as R52 routinely washes up "vital areas" of the body twice a day. A full bed bath had not been offered as an alternative to the shower which would be less fatiguing to R52. R52 stated had received a shower each Monday evening for the last two weeks.

R52's care plan dated 1/15/14, indicated R52 was bathed at least weekly with interventions including limited bathing assist with every other week shower, set up, and assist with transfer required.

Progress note dated 1/13/14, indicated R52's family member had requested every other week shower for R52. Both R52 and the family member agreed to weekly showering after meeting with the nurse manager.

An undated bath list indicated R52 was on the

The facility has developed a policy for monitoring of resident choice in regards making their own choice of their daily needs and plan of care. Upon admission the choice to decide upon bathing preference has been added to the Social Worker/Admission checklist to ensure that preference of choice is correct. Bathing preference will again be reviewed upon the Initial Care Conference with the resident, then quarterly, annually and upon the request of the resident.

Resident 22 POC was reviewed for choice and her bath was changed on the first day of survey (1-13-2014) to every other week as she requested.. The resident has been since discharged to an Assisted Living on 2-6-2014

Each resident POC will be reviewed by 2/21/14, to ensure that their bathing preference is according to their choice. After that, it will be reviewed quarterly and PRN at their request moving forward and changed as requested.

Staff education was held immediately upon findings and again on 2-5 2014 and 2-11-2014

Random audits will be completed by DON/designee, 2 X a week X 4, then weekly thereafter if compliance is met.

Auditing will also be done for the next quarter by Social Service reviewing the Guardian Angel Interview forms; to ensure any changes in residents bathing choice is met.

Audit results will be brought to QAPI for review and further recommendations.

Staff member responsible for compliance: Social Service/DON/Administrator/Activity Director

Completion date: 2-21-14

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F 242	Continued From page 2 weekly bath schedule for every Monday evening. On 1/16/14, at 10:45 a.m. registered nurse (RN)-C stated the standard bathing frequency upon admission to the facility was weekly. RN-C confirmed a conversation with R52 and a family member had occurred regarding R52's request to receive a bath every other week. RN-C verified both R52 and family member were agreeable to weekly showering. RN-C further confirmed R52 was given the option to bathe less frequently, but had not documented the option. On 1/16/14, at 1:55 p.m. the director of nursing (DON) stated while the facility sets everyone up upon admission for receiving a weekly bath, it is the residents' choice to be bathed less often than weekly, and that choice should be honored. A Self Determination and Participation Policy (undated) directed each resident would be allowed to choose activities, schedules, and health care consistent with their interests, assessments, and plans of care and would include bathing schedules. The policy further directed in order to facilitate resident choices, staff should inform residents and family members of the resident's right to self-determination and gather information, document, and care plan those preferences.	F 242		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is	F 249		

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F 249	Continued From page 3 eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a qualified activity director. This had the potential to affect all 41 residents currently residing in the facility. Findings include: On 1/16/14, at 9:30 a.m. the social worker (SW)-A was interviewed and stated she was a licensed social worker, and had never worked in an activities department in a health care setting. SW-A stated she started working for the facility in November of 2013, and was given the title of Director of Social Services/Activities. SW-A further stated she supervised the activity department. On 1/16/14, at 10:47 a.m. the administrator was interviewed and verified SW-A was the activity director. The facility was unable to provide a policy and	F 249	**F249** **The facility has placed a qualified activity professional by state requirements in charge of the department with the title of Activities Director. This staff member has been educated in the assessment process and will be responsible for compliance. A revised job description has been developed on the requirements for the activity director.** **All staff educated on the change in the department on 2-5-2013 and 2-11-2014** **Change was brought to QAPI on 2-10-2014** **Staff responsible: Administrator/Social Service** **Completion date:** 2-21-14	

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F 249	Continued From page 4 procedure on the requirements for the activity director.	F 249		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plans for for 1 of 5 residents (R22) reviewed for unnecessary medications. Findings include: R22's care plan did not address risk factors,	F 279	**F279** **The facility immediately reviewed the Care Plan and included the side effect, and signs and symptoms of bleeding in regards to Coumadin use on the following resident: R 22.** **Care plans for all current residents on an anticoagulant will be reviewed by 2/14/14 and revised prn to include monitoring for the risks of anticoagulant use. All newly admitted residents on an anticoagulant will have their care plans audited for compliance.** **The facility policy and procedure on the care planning procedure of monitoring for the risk of Coumadin usage and was brought to QAPI on 2-10-2014 for review and revision as needed.** **Auditing of care plans will be done randomly by DON/designee, 2 X week X 4 weeks, 1x week X 4 weeks, then upon initial care plan and quarterly on all current residents.** **Education has been completed with licensed staff on 1-16-2014** **Education again presented on 2-5-2014 and 2-11-2014** **Audit results will be brought to QAPI for review and any additional recommendations.** **Responsible staff: DON/ Nurse Managers** **Completion date:** 2-21-14	

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F 279	Continued From page 5 including a recent history of bleeding, related to the use of Coumadin (an anticoagulant medication used to decrease the the clotting ability of the blood The physician's 30 day review dated 10/24/13, indicated R22's diagnosis included cerebral vascular accident (CVA, commonly known as a stroke), and atrial fibrillation. R22 had orders to receive Coumadin (for atrial fibrillation) 6 milligrams (mgs) on Monday, Wednesday and Friday, and 7 mgs the rest of the week. R22 was hospitalized from 11/18/13, through 11/21/13, for a gastrointestinal bleed. On 1/16/14, at 10:01 a.m. registered nurse (RN)-B was interviewed and verified the care plan did not address the use of coumadin, monitoring for side effects, or signs and symptoms of bleeding. On 1/16/14, at 1:40 p.m. the director of nursing (DON) stated the use coumadin, monitoring for side effects, and signs and symptoms of bleeding should be included on the care plan. The facility policy and procedure on resident care plan dated 9/10, directed concerns and problems to be care planned, including problems relating to diagnoses and physician's orders.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 6 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement interventions to minimize skin wounds for 1 of 3 residents (R20) reviewed for wounds. Findings include: R20 was not provided pillows under the feet or sheepskin to the wheel chair foot rests/extensions as the assessment indicated was needed. The quarterly Minimum Data Set (MDS), dated 10/16/13, indicated R20 had diagnoses that included dementia and seizure disorder. The MDS indicated R20 had severe cognitive impairment, had a history of physical and verbal abusive toward others and care refusals. R20 was incontinent of bowel and bladder, required extensive physical assist with two or more staff for transfers and activities of daily living. R20 was at risk for pressure ulcers, required assistance with repositioning, and had pressure reducing devices in bed and chair. Progress notes on 11/12/13, at 5:23 p.m.,	F 309	**F309** **Resident 20's POC was reviewed with the following changes: On 1-16-2014 Occupational Therapy did an evaluation of the residents wheelchair positioning and foot positioning. New support cushions were placed on the legs of the w/c with elevating foot pedals. Since this change the residents left heel injury has improved.** **All current residents with wheelchair leg rests were reviewed by _2-21-2014 to ensure that the correct equipment is in place.** **All newly admitted residents with wheelchair leg rests will be reviewed and audited for compliance in regards to their individualized POC.** **Random auditing of wheelchair leg rests will be completed 2x week x 4 weeks. If compliance is met random audits will be continued on a weekly basis.** **Audit results will be brought to QAPI for review and any further recommendations.** **Education was completed for nursing staff on R20s POC on 1-16-2014. Additional education was provided on 2-5-2014 and 2-10-2014.** **Staff responsible: DON, Nurse Managers, Administrator and Social Service Director** **Completion date:** 2-21-14	

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F 309	Continued From page 7 indicated bruises to the left heel. The strap to the w/c footrest was removed and lamb's wool cushioning applied to protect R20's feet. Progress notes dated 11/20/13, at 10:47 a.m. indicated the area measured 1.2 cm by 2 cm, irregular shaped firm closed area, center 0.5 cm by 0.5 cm greenish yellow with surrounding area firm flesh color. Routine wound monitoring indicated the heel developed chronic discoloration of the intact area due to contact with the w/c footrests during episodes of agitated behavior. R20's care plan dated 1/15/14, directed monitoring of a "discolored area" to the medial left heel every shift and an Allevyn border dressing to left heel to be changed every 3 days. R20 was to wear slippers or shoes when out of bed. R20 required extensive assist of two staff to turn and reposition every 2-3 hours, float heels on pillow in bed every shift. The care plan did not address the sheep skin cushioning on the w/c foot rest. The nursing assistant To Do List Report indicated R20 required extensive assistance of two staff to turn and reposition every two to three hours. The To Do List Report indicated R 20 heels were to float on a pillow when in bed. The To Do List did not address the use of the sheep skin cushioning on the w/c foot rest or extensions. R20 was observed in her wheel chair on 1/15/14, at 11:50 a.m. without sheepskin on the w/c foot rest. At 3:15 p.m. R20 was laying on the right side in bed without a pillow floating the left heel off of the bed. At 4:00 p.m. R20 was sitting in the w/c with no sheep skin on the w/c extensions or foot rests. At approximately 5:45 p.m. R20 was	F 309		

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F 309	Continued From page 8 transferred from her wheel chair to her bed by nursing assistants (NA-D & NA-E). Evening cares were completed but the heels were not elevated off the bed. NA-D was interviewed and stated there had been sheep skin on the w/c pedals but didn't know where it went. On 1/16/14 at 8:10 a.m. R20 was laying in bed with no pillow under the feet. The left heel was was on the bed with pressure on the left heel wound. Registered nurse (RN-B) was interviewed at approximately 8:30 a.m., and stated there should be a pillow under R20's feet to reduce pressure on the heels. On 1/16/14, at 9:30 a.m., RN-B measured the left heel wound. There was a scab in the center that measured .5 cm by .7 cm and the total area measured 1.2 cm by 2.1 cm. NA-C was interviewed on 1/16/14, at approximately 9:30 a.m., and stated there was no pillow under R20's feet when she made rounds at approximately 7:00 a.m.. NA-C stated she was going to get R20 up soon so she didn't put a pillow under her feet. On 1/16/14 at 1:35 p.m., RN-B was interviewed confirmed the care plan directed sheep skin on R20's w/c foot rests and extensions. RN-B did not know how long the sheep skin had been off R20's w/c foot rests or wheel chair extensions. The Skin Ulcer Protocol dated 12/1/13, directed interventions were to be in place for all types of wounds.	F 309		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 provide assistance with fingernail trimming for 1 of 1 resident (R52) reviewed for activities of daily living. Findings include: On 1/13/14, at 2:50 p.m. R52 was observed with long fingernails on both hands with several jagged edges and dark colored debris underneath the nail tips. R52 stated a weekly shower was scheduled for Mondays. R52 further stated no one had offered to trim the nails and, "I know they are a mess, and I cannot do them myself." R52 stated the nails needed to be cleaned and trimmed. On 1/15/14, at 6:56 p.m. R52 was again observed to have long, jagged and dirty fingernails on both hands. R52 stated had a shower on Monday late afternoon, but no one had offered to trim the nails. R52's face sheet dated 1/6/14, indicated	F 312	F312 Resident 52 had her nail care completed on 1-16-2014. Resident 52 has since been discharged to an Assisted Living on 2-6-2014 All current residents were checked by 1-20-2014 to ensure proper nail care had been completed per their POC. All dependent residents will be monitored to ensure that proper nail care is completed per their POC on a daily basis X 2 weeks, then weekly thereafter on their bath day. If a resident refuses nail care at that time, the nurse will be notified and this will be documented and will be passed on to the next shift to follow up. All newly admitted residents POC will be addressed for nail care needs. Random audits of residents nails will be completed 2X per week for one month and then weekly thereafter by DON/designee. Audit results will be brought to QAPI for review and further recommendations. Nursing staff education regarding nail care was provided on 1-16-2014, 2-5-2014 and 2-11-2014 Staff responsible: DON , Nurse Managers and Social Service Director Completion date: 2-21-14	

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F 312	Continued From page 10 diagnoses included macular degeneration and cerebrovascular accident. The Minimum Data Set (MDS) dated 1/16/14, indicated R52 was cognitively intact, had severely impaired vision, required limited assistance with personal hygiene activities and physical help with bathing. R52's Care Planning Report dated 1/15/14, indicated R52 required limited assistance with bathing after setup, with personal hygiene and grooming tasks. The report further indicated R52 was legally blind and was only able to see lights and shapes. On 1/16/14, at 8:43 a.m. nursing assistant (NA)-A stated R52 had a shower on 1/13/14, late afternoon but was not provided fingernail care at the time. NA-A further stated fingernail care was usually provided to a resident who was not able to trim and care for their own nails on bath day. NA-A confirmed fingernails should be trimmed and cleaned when noted to be long, jagged, and/or dirty. On 1/16/14, at 10:45 a.m. registered nurse (RN)-C stated fingernail care was expected to be provided on bath day as part of the grooming process. An undated policy titled Care of Nails (Finger and Toe) indicated residents were to be offered cleaning and cutting of nails weekly and as needed.	F 312		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 11 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop parameters for use of as needed (PRN) analgesic and antipsychotic medication for 1 of 5 residents (R34) whose medications were reviewed. Findings include:	F 329	F329 The Consultant Pharmacist reviewed resident 34's medications and the following parameters for the use of the PRN pain medication and PRN Antipsychotic medication were recommended: 1-17-2014 A Physician's order was obtained for the PRN pain medication and antipsychotic medication parameters for use. All Nursing staff were trained on R34's POC regarding specific parameters for use of PRN pain and antipsychotic medications and general education on PRN use, by 1-20-2014 . The Consultant Pharmacist completed a review of each resident with a PRN pain medication and /or PRN antipsychotic medications to ensure parameters for use are specified. All current resident charts have been reviewed and updated to ensure correct parameter usage for the PRN pain medications and PRN Antipsychotic medication usage is correct. All newly admitted resident charts will be reviewed to ensure that if they are on a PRN pain or PRN Antipsychotic medication that specific parameters are in place, to ensure proper use of the drug. Random audits of residents use of the PRN pain and/or antipsychotic medication will be completed 2X week X4, then weekly X4 by DON/designee, to ensure PRNs are being used as ordered . Audit results will be brought to QAPI for review and further recommendations. Staff responsible: DON, Nurse Managers Completion date: 2-21-14	

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F 329	Continued From page 12	F 329		

R34's physician's orders signed and dated 12/11/13, included Haloperidol 1 milligram (mg) daily at 1:00 p.m. and 2 mg daily at 5:00 p.m. for anxiety disorder, dementia with psychosis, and depression; Haloperidol 1 mg twice daily PRN for psychosis, dementia with psychosis, depression, and agitation; Percocet 5-325 mg three times daily for aftercare of traumatic fracture of the upper leg, fracture of the neck of the femur and pain; and Percocet 5-325 mg every 4 hours PRN for fracture of the neck of the femur; and Tylenol 325-650 mg every 4 hours PRN.

The Mood/behavior/psychiatric medication evaluation dated 11/3/13, identified multiple behaviors and directed the use of PRN Haloperidol when non-pharmacological interventions failed. The evaluation indicated R34 was assessed for pain on a regular basis and with any behavioral episodes. The assessment did not address potential symptoms more frequently related to pain as opposed to agitated dementia with psychosis.

The quarterly Minimum Date Set (MDS) dated 11/6/13, indicated R34 had short and long term memory deficits, severely impaired cognitive skills, displayed occasional physical and verbal behavioral symptoms and had occasional wandering.

On 1/15/14, at 1:04 p.m. R34 was observed seated in wheelchair, attempting to stand and walk on own. Nursing assistant (NA)-A pushed R34 in the wheelchair off the unit returning

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	245258	A. BUILDING _____ B. WING _____	01/16/2014

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 329	Continued From page 13 shortly. At 1:10 p.m. NA-A applied a gait belt and assisted R34 to stand with the walker, stating they were going for a walk. At 2:24 p.m. R34 was observed sitting in wheelchair near the nurses' station, finishing a cup of coffee. NA-A approached R34, applied a gait belt, assisted R34 to stand, and took R34 for a walk using a walker. At 5:34 p.m. R34 was seated in wheelchair in hallway near dining area on the unit. R34 was observed to attempt to stand on own. R34's wheelchair alarm sounded, and NA-D responded, applied a transfer belt around R34, and walked with R34 down the hall with R34 using a walker. On 1/16/14, at 11:00 a.m. NA-A stated R34 is often restless and agitated. NA-A further stated R34 can be re-directed with going for a walk or providing R34 a slot machine for distraction. NA-A stated R34 has never complained of pain when providing cares. On 1/16/14, at 12:40 p.m. licensed practical nurse (LPN)-A stated the cause of R34's behaviors is sometimes difficult to determine. LPN-A further stated R34's behaviors are more common later in the day. LPN-A confirmed the Percocet is often tried first rather than the Haldol as it is difficult to know if R34 is having pain or experiencing behaviors due to psychosis. LPN-A verified R34 will display non-verbal behaviors of rubbing legs or knees indicating pain, but R34 will rarely verbalize pain presence. LPN-A confirmed R34's care plan was not up to date with interventions related to pain. LPN-A went on to state R34 has not received the Tylenol in a very long time as it did not help R34's pain. On 1/16/14, at 1:45 p.m. registered nurse (RN)-C	F 329		

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F 329	Continued From page 14 stated R34's care plan did not reflect target behaviors for pain and use of Percocet for pain control. RN-C further stated R34 displays non-verbal indicators of pain, including rubbing legs and knees along with some restlessness, and confirmed Haldol is indicated for aggression and agitation, when non-pharmacological intervention are unsuccessful. On 1/16/14, at 2:05 p.m. the director of nursing (DON) stated R34's care plan should have been updated regarding the use of Percocet for pain versus Haldol for "behaviors". The DON further stated target behaviors for both need to be outlined for use in the care plan and the nurses should be using the Haldol for behaviors related to psychosis and the Percocet for pain. The DON went on to state the non-pharmacological measures should be used first, medications second, to not use the Percocet for behaviors associated with the psychosis, and the medications' effectiveness should be documented. The DON stated R34's Celexa had been tapered and then discontinued on 12/11/13, and stated the behaviors seemed to increase since that time. The medications administration record (MAR) for the month of December 2013, indicated R34 received PRN Percocet 28 times. The reasons for administration included leg/knee pain, impulsiveness, restless, combative, hitting, exit seeking, and aggressiveness. During December 2013, the MAR indicated Haloperidol was administered nine times (twice simultaneously with Percocet) for aggression, restlessness, rubbing knees, punching staff and	F 329		

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F 329	Continued From page 15 combativeness. The MAR for the first two weeks of January 2014 indicated R34 was given 10 doses of PRN Percocet. The reason for administration was documented eight times with reasons including up and down, restless, exit seeking, hitting, leg pain and restless legs. During January 2014, PRN Haloperidol was administered four times (twice simultaneous with Percocet) for up and down, restless, exit seeking and hitting.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow proper food handling practices observed during meal service and during snack time. This had the potential to affect 14 of 22 residents observed during meal time and 1 of 1 resident (R48) observed during snack time. Findings include:	F 371		

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F 371	Continued From page 16 During the meal service observation on 1/13/14, at 10:35 a.m. cook-A donned a pair of disposable gloves and began serving the brunch meal which consisted of a liverwurst sandwich or blueberry donut, hot cereal, scrambled eggs, peach slices, and assorted juices. Cook-A was observed to handle the resident meal tickets/menus that were completed by staff/residents before selecting the appropriate food items. Cook-A was observed to place a sandwich or donut onto the plates with the same gloved hands for approximately 7 residents. The dietary manager (DM)-D was in and out of the food service area on several occasions observing the meal service. At 10:45 a.m. cook-A was observed to remove the gloves, open the large reach-in refrigerator in the kitchen, and take out a container of butter. Cook-A donned clean gloves and continued to handle the meal tickets and donuts or sandwiches in the same manner for approximately five more residents. At 10:47 a.m. cook-A removed the gloves and went into the kitchen to get bread out of a bag. Cook-A opened the bread bag, applied new gloves, reached into the bread bag and removed 2 slices of bread. Cook-A closed the bread bag and returned to the service area, continuing the meal service, handling the menus and unwrapped food. At approximately 10:57 a.m., cook-B entered the food service/kitchen area, donned gloves, and proceeded to handle the meal tickets and serve unwrapped sandwiches and donuts. DM-D was observing the switch from Cook-A to Cook B for the brunch food service. At 11:00 a.m. cook-B removed the gloves and answered the telephone in the kitchen. Cook-A returned to the food service table, donned new gloves, handled a meal ticket,	F 371	**F371** Dietary staff Cook A and Cook B were immediately re-educated on the proper and safe handling of food in a sanitary manner. Education also immediately provided on the proper use of when to use gloves along with proper hand washing. NAR-D was immediately re-educated on the proper and safe handling of food in a sanitary manner. Education was also provided on the proper use of when to use gloves and proper hand washing. All Dietary staff were trained on 1-16-2014 and 1-18-204 in regards to the safe handling of food in a sanitary manner. All other staff members were trained on 2-5-2014 and 2-10-2014 in regards to the safe handling of food in a sanitary manner. Random audits of food service are being conducted on a daily basis at random meal times by Dietary staff and by DON/designee. Random audits of snack passes with safe handling of food is being conducted daily to ensure compliance. Random audits of food handling will continue on a daily basis for one month and then weekly thereafter. Results of audits will be brought to QAPI for review and further recommendations. Responsible staff: Administrator, Dietary Manager, DON, Nurse Managers Completion date: 2-21-14	

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F 371	Continued From page 17 and placed a donut on a plate for a resident. The DM-D stated cook-A left the food service due to feeling ill. On 1/13/14, at 11:07 a.m. cook-A stated gloves were worn with direct food handling and should be changed when a break in task occurs. Cook-A was not aware gloves should be changed when touching non-food items, such as the resident meal tickets. Cook-A verified the lack of hand hygiene with glove changes and should have washed or sanitized hands. DM-D stated did not observe either cook-A or cook-B handling the meal tickets and then the donuts and/or the sandwiches. DM-D confirmed the cooks should not be touching the non-food items and then the ready-made food with the same gloves and should have used tongs instead to pick up and place the donuts and/or sandwiches on resident plates. DM-D verified cook-A did not wash hands after removing the gloves twice during the meal service and should have at least sanitized hands. R48 was assisted with a snack on 1/15/14, at 6:37 p.m.. The nursing assistant (NA)-D was observed sitting next to and assisting R48 with a sandwich. NA-D was observed, with bare hands, held the sandwich for R48 to take a bite. Thick white sauce dripped from the sandwich onto NA-D's hands when R48 took several bites of the offered sandwich. NA-D walked to the nurses' station sink and washed both hands, exclaiming had got mayonnaise on both hands. NA-A stated she did not know there was a problem with bare hand food contact.	F 371		

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F 371	Continued From page 18 On 1/16/14, at 10:30 a.m. the DM-D stated no bare hand food handling should occur when NA's are assisting residents to eat, like a sandwich. The DM-D further stated the NA's should wear gloves or cut up the sandwich into small bite size pieces to feed the resident with a fork. A NO Bare Hand Contact policy issued 2/29/12, directed staff to not use bare hands (clean or not) to prepare ready to eat foods or serving the food. The Policy further directed staff were not to use bare hands to hold toast, bread, rolls, etc when assisting at meals or snack times. The Policy also directed hands must be washed between any contaminations including tray tickets.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the consultant pharmacist (CP) failed to identify the lack of parameters for use of as	F 428		

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F 428	Continued From page 19 needed pain medication and antipsychotic medication for 1 of 5 residents (R34) whose medications were reviewed. Findings include: The consultant pharmacist did not identify the lack of parameters for use of as needed (PRN) Percocet (narcotic pain medication) and PRN Haloperidol (antipsychotic medication). R34's physician's orders signed and dated 12/11/13, included Haloperidol 1 milligram (mg) daily at 1:00 p.m. and 2 mg daily at 5:00 p.m. for anxiety disorder, dementia with psychosis, and depression; Haloperidol 1 mg twice daily PRN for psychosis, dementia with psychosis, depression, and agitation; Percocet 5-325 mg three times daily for aftercare of traumatic fracture of the upper leg, fracture of the neck of the femur and pain; and Percocet 5-325 mg every 4 hours PRN for fracture of the neck of the femur; and Tylenol 325-650 mg every 4 hours PRN. The Mood/behavior/psychiatric medication evaluation dated 11/3/13, identified multiple behaviors and directed the use of PRN Haloperidol when non-pharmacological interventions failed. The evaluation indicated R34 was assessed for pain on a regular basis and with any behavioral episodes. The assessment did not address potential symptoms more frequently related to pain as opposed to agitated dementia with psychosis.	F 428	F428 The Consultant Pharmacist has reviewed resident 34 and newly added parameters for the use of PRN pain and PRN Antipsychotic medication usage has been completed. 1-17-2014 The Consultant Pharmacist has completed a review of each resident Drug Regimen to ensure that each resident has parameter for use of PRN pain medication and PRN Antipsychotic medications. All current resident charts have been reviewed and updated to ensure correct parameter usage for the PRN pain medications and PRN Antipsychotic medication usage is correct. All newly admitted resident charts will be reviewed to ensure that if they are on a PRN pain or PRN Antipsychotic medication that parameter are implemented to ensure proper use of the drug. Random audits will be completed 2x per week for one month then weekly for one month and then quarterly to ensure compliance. All results will be brought to QAPI for further recommendations. Staff education was held on 2-5-2014 and 2-11-2014 Staff Responsible: DON, Nurse Managers Completion date: 2-21-14	

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F 428	Continued From page 20 The quarterly Minimum Date Set (MDS) dated 11/6/13, indicated R34 had short and long term memory deficits, severely impaired cognitive skills, displayed occasional physical and verbal behavioral symptoms and had occasional wandering. The medications administration record (MAR) for the month of December 2013, indicated R34 received PRN Percocet 28 times. The reasons for administration included leg/knee pain, impulsiveness, restless, combative, hitting, exit seeking, and aggressiveness. There was no evidence that Tylenol was administered during the month. During December 2013, the MAR indicated Haloperidol was administered nine times (twice simultaneously with Percocet) for aggression, restlessness, rubbing knees, punching staff and combativeness. The MAR for the first two weeks of January 2014 indicated R34 was given 10 doses of PRN Percocet. The reason for administration was documented eight times with reasons including up and down, restless, exit seeking, hitting, leg pain and restless legs. During January 2014, PRN Haloperidol was administered four times (twice simultaneous with Percocet) for up and down, restless, exit seeking and hitting. The PRN MAR lacked evidence that Tylenol was administered during the month. The undated Record of Medication Regimen Review indicated R34's medications were reviewed monthly per the consultant pharmacist.	F 428		

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F 428	Continued From page 21 The review dated 11/11/13, noted the consulting pharmacist (CP) identified R34 had behaviors one time with Haloperidol given three times; the review dated 12/12/13, noted the CP recorded R34's Celexa had been discontinued and R34 had experienced behaviors three times and received the Haldol one time. The drug review form also included some handwritten information between the 11/11/13, review and the 12/12/13, review to include PRN (as needed) Percocet almost daily for leg pain. On 1/22/13, at 3:00 p.m. the consultant pharmacist (CP-G) was interviewed via telephone and stated R34's behavioral symptoms escalated in December after the Celexa, which was used for R34's anxiety, was discontinued. CP-G further stated it would take about one month to see if the discontinuation of the Celexa had any effect on R34's behaviors. CP-G stated that facility staff only used the PRN Percocet and Haloperidol after non-pharmacological interventions failed.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 22 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff followed proper hand hygiene to prevent the transmission of disease and infection for 1 of 1 resident (R8). Findings include: An observation on 1/16/14, at 8:28 a.m. revealed nursing assistant (NA)-C assisting R8 with perineal care. NA-C, with gloved hands, removed	F 441	F441 Infection Control Staff member NA-C was immediately re-educated our the facility Infection Control Program which included the proper hand washing between glove changes, when completing resident cares, on 1-16-2014. All other staff have been re-educated on proper use of gloves and hand washing during resident cares on 1-16-2014, 1-18-2014, 2-5-2014, 2-11-2014. Random audits will be completed 2X week X 3 weeks, then 1X week thereafter on alternating shifts, by DON/designee, to ensure compliance on an ongoing basis. Audit results will be brought to QAPI for review and further recommendations. Staff responsible: DON, Nurse Mangers and Administrator Completion Date: 2-21-14	

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F 441	Continued From page 23	F 441		

and emptied R8's urinal. NA-C then removed R8's soiled incontinent product and placed in the soiled receptacle. NA-C with soiled gloves on placed a clean incontinent product in R8's perineal area. NA-C with soiled gloves cleansed R8's perineal area and secured the incontinent product on R8. NA-C removed the soiled gloves and donned clean gloves without hand sanitizing or washing hands with soap and water. NA-C washed R8's face with a wet cloth and placed the cloth in a plastic bag. NA-C removed soiled gloves and donned clean gloves and applied lotion R8's legs. NA-C removed the soiled gloves and assisted R8 with putting clothes on the upper torso. NA-C donned clean gloves and placed R8's dentures in the mouth. NA-C removed the gloves and completed dressing the lower torso of R8. NA-C donned gloves and washed R8's glasses and gave a ball cap to R8 to wear. NA-C removed the soiled gloves and opened R8 cereal and poured milk into the bowl. NA-C donned gloves and dumped the wash basin, cleansed with a wipe and put the wash basin away. NA-C bagged up the linen and garbage and removed the soiled gloves. NA-C used a hand sanitizer to clean the hands.

An interview on 1/16/14 at 9:00 a.m. with NA-C revealed that the hands should have been sanitized or washed after NA-C touched anything while providing care to R8. NA-C indicated the hands should have been sanitized whenever the soiled gloves were taken off.

An interview on 1/16/14 at 9:52 a.m. with the director of nursing (DON) indicated that employees are to perform hand hygiene before donning gloves and after removal of gloves. The DON stated that staff should have washed hands

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F 441	Continued From page 24 after a dirty task, after perineal care, and prior to putting on a clean incontinent product on a resident. The facility's Policy and Procedure on Hand washing revised date 10/28/03 indicated hand washing needed to occur after contact with blood, urine, feces, oral secretions, mucous membranes or broken skin. The policy also indicated that before and after wearing gloves hand washing needed to occur.	F 441		

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

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FRANCISCAN HEALTH CENTER	3910 MINNESOTA AVENUE DULUTH, MN 55802

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Franciscan Health Center, Building #1, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19, Existing Health Care. Franciscan Health Center Building #1 is a 2 story building with a small partial basement. The 2nd level is all office space with no resident access The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(000) construction. In 1970 an addition was constructed that was determined to also be of Type II(00) construction. Because the original building and the addition meet the construction type for existing buildings, this building was surveyed to Chapter 19, existing health care. This building is fully fire sprinkler protected. The entire facility has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor. Building #1 is properly 2 hour fire separated from building #2 which was constructed in 2006 The facility has a licensed capacity of 44 beds and had a census of 41 at the time of the survey.	K 000	FS 2-14-14 Please see attached waiver RECEIVED FEB 13 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

2-25-14 DC: EXIT: 1/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah DeLuca	Administrator	2-13-2014

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 **01 - MAIN BUILDING 01** B. WING _____	**01/14/2014**

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

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

F5258022

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING 02 - FRANCISCAN HEATLH CENTER B. WING _____	01/14/2014

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

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K 000	INITIAL COMMENTS Juntunen, Jeff FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES K TAGS TO: Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By email to: Marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done	K 000	B ok 2-14-14 w/ AW for K55 RECEIVED FEB 13 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

See Building One for Signature

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 02 - FRANCISCAN HEATLH CENTER B. WING _____	01/14/2014

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FRANCISCAN HEALTH CENTER	3910 MINNESOTA AVENUE DULUTH, MN 55802

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K 000	Continued From page 1 to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. THIS INSPECTION ONLY COVERS THE 2006 ADDITION TO FRANCISCAN HEALTH CENTER. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Franciscan Health Center, Building #2, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NEW Health Care. Franciscan Health Center Building #2 is a 2006 addition and is a one (1) story building with no basement. The construction type is determined to be Type II(000). Building # 2 is properly fire separated from building #1. The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The entire facility has a licensed capacity of 44 and a census of 39 at the time of inspection	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING 02 - FRANCISCAN HEATLH CENTER B. WING _____	01/14/2014

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is not met, as evidenced by:	K 000		
K 055 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Every patient sleeping room has an outside window or outside door. The allowable sill height does not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms intended for occupancy for less than 24 hours. Window sill height for limited care facilities does not exceed 44 inches (112 cm) above the floor. 18.3.8 This STANDARD is not met as evidenced by: Based on observation, an addition was constructed to the front of the building in 2006. The addition created a condition such that some resident rooms no longer have an outside window. This deficient practice could affect all occupants including residents, staff and visitors. Findings Include: During the facility tour between on 1-14-14 between approximately 9:00-10:30AM, it was observed that 6 resident rooms do not have a window to the exterior, on the street side, this is because of the building addition. The windows now face into an enclosed courtyard. This deficient practice was confirmed by the administrator (DG) at the time of exit. * Waiver Recommended *	K 055	AW See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, February 14, 2014 1:53 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: jeffrey.juntunen@state.mn.us; 'ddegrio@viewcrest.sfhs.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Franciscan Health Center (245258) K55 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Franciscan Health Center is again requesting an annual waiver for K55, resident sleeping rooms with no outside windows. The exit date was 1-16-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Franciscan Hlth Center 245058 1 of 2

An annual waiver is requested for K55 for the flowing reasons:

A. There is no adverse effect of the health and safety of the facility's residents and staff since the completion of the building project.
   1. The building has automatic shut down of all ventilation fans upon a detection of smoke or activation of the fire alarm system.
   2. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13.
   3. Resident sleeping areas are equipped with hard wired single station smoke detectors or heat activated sprinkler systems.
   4. The facility is smoke free and signs to the effect are posted in all major entrances.
   5. Annual service and maintenance contracts exist to service all the facility's fire protection systems.
   6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.
   7. Fire drills are conducted quarterly on each shift.

B. A renewal waiver for one year is being requested for the 7 resident rooms that have windows facing an interior courtyard.

   1. The affected rooms are located in a fire-resistive, fully sprinkled portion of the building
   2. The construction type of the outside/inside of building
   3. The building alarm system is monitored to provide automatic fire department notification
   4. There is a fire safety plans that complies with LSC 19.7.2.2. Every employee is trained upon hire of the LSC and yearly.
   5. Staff to resident ratio 1:6 day shift 1:6 afternoon shift 1: 14 on the NOC shift
   6. This condition was approved by the Minnesota Department of health, prior to construction of the Atrium spaces.
   7. The fire and safety of the residents is not negatively affected by this condition.
   8. A two (2) hour fire wall exists separating the new addition of building number (1) one from building number (2) two building which is completely upgraded to new construction standards.
   9. Smoke compartments in the building number two is one with less than 22, 500 square feet in the building.

F Sheehan Fire Safety Supervisor State Fire Marshal 2-14-14

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

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February 13, 2014

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

Mr. Sheehan,

Attached is the required waiver for our K tag from our recent MDH survey. If you have any questions, please do not hesitate to call.

Thank you,

Sincerely,

Deb De Grio, Administrator