DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: X4ZT

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARI I -	TO BE COMPI	LEIEDBY	THE STAI	IE SURVEY AGENCY		Facility ID: 00865
1. MEDICARE/MEDICAID PROVIDE (L1) 245258 2.STATE VENDOR OR MEDICAID NO (L2) 551218200		3. NAME AND AI (L3) FRANCISC (L4) 3910 MINN (L5) DULUTH, N	AN HEALTH ESOTA AVEN	CENTER	(L6) 55802	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
6. DATE OF SURVEY 05/09/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	44 (L18) 44 (L17)	Complianc1. A B. Not in Comp		ram	And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code * Code: A*	6. Scope of 7. Medical	Services Limit Director oom Size
14 LTG GERTIFIED DED DREAWDON	ID.	Requirements	and/or /applied	warvers.		(E12)	
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 44	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Chris Campbell, HFE NEI	l		05/23/2016	(L19)	Mark Meath	, Enforcement Spe	cialist 06/29/2016 (L20
PAR	T II - TO BE	COMPLETED 1	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIBILI _X 1. Facility is Eligible to Pa 2. Facility is not Eligible	rticipate		MPLIANCE WITH	H CIVIL	21. 1. Statement of Fin. 2. Ownership/Cont. 3. Both of the Abov.	rol Interest Disclosure St	
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE		4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION 02/01/1983	BEGINNINC	G DATE	ENDING DA	TE	VOLUNTARY 0 01-Merger, Closure 02-Dissatisfaction W/ Reimbur	05-Fail	UNTARY to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminati	ion	to Meet Agreement
25. LTC EXTENSION DATE:	A. Suspension	VE SANCTIONS n of Admissions:	(L44)		04-Other Reason for Withdrawal	, <u>Othe</u> i	vider Status Change
(L27)	B. Rescind St	uspension Date:	(L++)				
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28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
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31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAI	L DATE			
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245258

June 29, 2016

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 May 6, 2016 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Weath

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

Telephone: (651) 201-4118

Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 23, 2016

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

RE: Project Number S5258025

Dear Ms. Degrio:

On April 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 31, 2016 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 May 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 9, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 31, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2016, effective May 6, 2016 and therefore remedies outlined in our letter to you dated April 13, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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

05/06/2016

Correction

Completed

05/06/2016

LSC

ID Prefix

Reg. #

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LSC

Reg. #

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ID Prefix F0465

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	POST-CERTIFICATION REVISIT REPORT									
	R / SUPPLIER / CLIA /	MULTIPLE CON	STRUCTION				DATE OF REVISIT			
IDENTIFIC 245258	CATION NUMBER Y1	A. Building B. Wing				Y2	5/9/2016 _{Y3}			
NAME OF	FACILITY			STREET ADDRESS, C	ITY, STATE	ZIP CODE				
FRANCISCAN HEALTH CENTER				3910 MINNESOTA AVE	ENUE					
DULUTH, MN 55802										
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05/06/2016

Correction

Completed

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05/06/2016

Correction

Completed

POST-CERTIFICATION REVISIT REPORT

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PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT
245258 _{Y1}	B. Wing	Y2	5/9/2016 _{Y3}
NAME OF FACILITY FRANCISCAN HEALTH CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	
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Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0011	05/06/2016	LSC K002	22	05/06/2016	LSC	K0025		05/06/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0052	05/06/2016	LSC Koos	56	05/06/2016	LSC	K0062		05/06/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	PA 101	Completed	Reg. #			Completed
LSC	K0104	05/06/2016	LSC K014	44	05/06/2016	LSC			
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							DULUTH, MN 55802				
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Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0052		05/06/2016	LSC	K0056		05/06/2016	LSC	K0062		05/06/2016
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ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
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REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	

3/29/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID:	A4L I	
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	PARI I -	TO BE COMPI	LETED BY	THE STAI	IE SURVEY AGENCY		Facility ID: 00865
1. MEDICARE/MEDICAID PROVID (L1) 245258 2.STATE VENDOR OR MEDICAID (L2) 551218200		3. NAME AND AI (L3) FRANCISC. (L4) 3910 MINNI (L5) DULUTH, M	AN HEALTH ESOTA AVEN	CENTER	(L6) 55802	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
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11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	44 (L18) 44 (L17)	Complianc1. A X B. Not in Con	ance With equirements be Based On: acceptable POC	ogram	And/Or Approved Waivers Of 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural Si 5. Life Safety Code * Code: B *	el 6. Scope of 7. Medical 1	Services Limit Director Dom Size
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
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16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE Date : Kimberly Settergren, HFE NEII 04/28/2016				(L19)	18. STATE SURVEY AGENCY That The Enforcement Specific Sp	th	Date: 05/16/2016
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22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREED BEGINNING		4. LTC AGREE		26. TERMINATION ACTION VOLUNTARY 0	<u>0</u> <u>INVOL</u>	(L30) UNTARY
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28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE			
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 13, 2016

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

RE: Project Number S5258025

Dear Ms. Degrio:

On March 31, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Franciscan Health Center April 13, 2016 Page 2

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: pam.kerssen@state.mn.us

Phone: (218) 308-2129 Fax: (218) 308-2122

Chris Campbell, Unit Supervisor

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 10, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 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

Franciscan Health Center April 13, 2016 Page 4

Upon receipt of an acceptable ePoC, 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 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.

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 July 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

Franciscan Health Center April 13, 2016 Page 5 this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 1, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

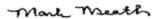
Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Franciscan Health Center April 13, 2016 Page 6

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

Sincerely,



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

Fax: (651) 215-9697

PRINTED: 04/22/2016 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		245258	B. WING		03/31/2016	
	PROVIDER OR SUPPLIER	≣R		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENT	-S	F 000			
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 282		5/6/16	
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on observate review, the facility for was followed for addindependent eating reviewed for nutrition. Findings include: R26's admission rediagnoses that include one side of the bodinfarction (stroke).	ion, interview and document ailed to ensure the care plan aptive equipment to aid in for 1 of 3 residents (R26) on. cord dated 12/30/16, indicated uded hemiplegia (paralysis of y) following a cerebral ange MDS dated 2/23/16,		Resident 26 was assessed by nursing/dietary assessment for use o (scoop plate) adaptive equipment per care plan with the following changes: Scoop plate was discontinued on 4-20-2016. All other residents who had orders for adaptive equipment will be re-assess by OT for the need of current adaptive equipment. All care plans will be reviewed and updated prn for residents who did ment the need for adaptive equipment.	r his r sed e	
ABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE	

Electronically Signed

04/22/2016

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245258	B. WING _		03	/31/2016	
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	≣R		STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	indicated R26 requinclude oversight, eR26's 2/25/16, nutrice Assessment (CAA) feed himself after sequipment. R26's 12/30/15, nutrice Assessment R26's 12/30/15, nutrice Assessment R26's 12/30/15, nutrice Assessment R26's 12/30/15, nutrice Assessment R26 was used adaptive equipprevent weight loss to provide adaptive a scoop plate and treating. On 3/29/16, at 4:40 dining room table, potatoes and green not have a scoop pregular ceramic plate On 3/30/16, at 11:0 eating biscuits and R26 did not have a on a regular ceram biscuit cut and did reason was observed to eat gravy. R26 was obspieces of the biscuit R26 at 100% of his staff encouraged R was no assistance obtain the necessal On 3/30/16, at 11:5 (DM) stated she hat equipment implement he kitchen staff was	red supervision with eating to ncouragement or cueing. tional status Care Area indicated R26 was able to ome set up with adaptive rition/eating care plan at risk for weight loss and oment. The goal was to . The care plan directed staff eating equipment, specifically o provide supervision with p.m. R26 was observed at a R26 was eating mashed beans with a fork. R26 did late, but was eating on a	F 28	All current residents moving newly admitted residents on assessment for need of ada equipment is determined by their care plan updated for the equipment. All staff who serve resident re-educated regarding their providing adaptive equipme plan and/or reading meal to meal pass. Daily audits of resident use adaptive equipment will be cleast 2x daily for 3 weeks, the x4 to ensure compliance. If met random audits will be convectly basis. Results of audits will be broad the QAPI Committee for revadditional recommendations. Education held on 4-27-2014-28-2016 for all staff. Responsible staff: DON, Die Nurse Managers and Admin Completion date:5-6-2016	ice the aptive of OT will have the use of such meals were mportance of nt per the care tkets during of their completed at nen 3x a week compliance is ontinued on a ught back to view and any s. 16 or		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245258	B. WING _		03/	31/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282 F 369 SS=D	scoop plate was lis 483.35(g) ASSISTI EQUIPMENT/UTE The facility must prand utensils for res This REQUIREMED by: Based on observareview, the facility fequipment to aid in residents (R26) rev Findings include: R26's admission rediagnoses that inclone side of the boor infarction (stroke). included depression hypertension, heard disease and headar R26's admission M1/6/16, indicated he with many activities including dressing, was independent was independent was indicated R26 required include oversight, eR26's 2/25/16, nutrassessment (CAA)	ted on his tray card. VE DEVICES - EATING NSILS rovide special eating equipment sidents who need them. NT is not met as evidenced tion, interview and document ailed to implement adaptive independent eating for 1 of 3 viewed for nutrition. ecord dated 12/30/16, indicated uded hemiplegia (paralysis of lay) following a cerebral Other diagnoses listed n, right shoulder pain, t disease, peripheral vascular	F 28		llowing ontinued uipment ure the oment. current ed for pment. were ance of the care during ir eted at x a week liance is ed on a	
	equipment.			Nurse Managers and Administrate Completion date: 5-6-2016		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		COMPLETED		
		245258	B. WING _		03	/31/2016	
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 369	indicated R26 was used adaptive equiprevent weight loss to provide adaptive a scoop plate and s. The 1/5/16, dietary was admitted on a with thin liquids. Remeal time due to him the 1/7/16, dietary admission weight wunder R26's usual. The note indicated weight history at a weight history at a compact of the second weight of the second weight history at a compact o	trition/eating care plan at risk for weight loss and pment. The goal was to a state at the care plan directed staff eating equipment, specifically supervision with eating. progress noted indicated R26 regular mechanical soft diet 26 was given a scoop plate at s stroke. progress note indicted R26's was 143 pounds and this was stated weight of 150 pounds. that family confirmed this care conference. y progress note indicated nt was 134 pounds which was cant weight loss (greater than be a summary sheet revealed R26 don a scoop plate to assist	F 36	,			
	was eating on a req approximately 80% On 3/30/16, at 11:0 eating biscuits and	d not have a scoop plate, but gular ceramic plate. R26 ate of his meal. 2 a.m. R26 was observed gravy and scrambled eggs. scoop plate, but was eating					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245258	B. WING			03/3	31/2016
	PROVIDER OR SUPPLIER	≣R		STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802)DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 369	biscuit cut and did r was observed to ea gravy. R26 was obspieces of the biscui R26 at 100% of his staff encouraged R was no assistance obtain the necessar On 3/30/16, at 11:4 adaptive equipmenturitional care planarea and the "cheat C-A stated these ar there was a change R26 used any adaptid not. When R26 the lists, C-A stated was to receive a scoon 3/30/16, at 11:5 know R26's name was ummary sheet, the On 3/30/16, at 11:5 (DM) stated adaptive a resident's tray tick of there was a new a communication slip changes to the full she has not audited implementation and kitchen staff was unneeded for R26. Do on the list and the stray card.	c plate. R26 did not have the not eat the biscuit, although he at approximately 25% of the served to attempt to pull at the with his fork without success. scrambled eggs. Although 26 to drink his fluids, there offered to cut up his biscuit or ry adaptive equipment. 8 a.m. cook (C)-A stated the was on R26's tray card, the assummary sheet in the service to sheet" by the service counter. The reviewed weekly unless in between. When asked if tive equipment C-A stated he 's name was pointed out on she was not aware that R26 cooped plate. 1 a.m. C-B stated she did not was on the nutritional care plants as well. 4 a.m. the dietary manager we equipment was indicated on the total and they kept a list as well.	F 3	69			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245258	B. WING		03/	31/2016	
	PROVIDER OR SUPPLIER SCAN HEALTH CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 369	assessed by facility with eating, so they evaluation.	apy was informed R26 was a staff to not need assistance had not done a therapy	F 3	69			
	(DON) stated anybo struggling and prov The DON stated the	a.m. the director of nursing ody can see a resident ide adaptive eating equipment. ey try to get occupational nursing can also implement					
	appropriate for dietable needed for a resident. The DM stherapy assessmen	a.m. the DM stated it is ary staff to see something may sident and use it for that stated typically an occupational it would follow. The DM stated in why this did not happen for					
F 431 SS=D	was requested but 483.60(b), (d), (e) [F 4	31		5/6/16	
	a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordan	als used in the facility must be ace with currently accepted bles, and include the ory and cautionary					

			(X3) DATE SURVEY COMPLETED		
		245258	B. WING		03/31/2016
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 431	applicable. In accordance with facility must store a locked compartment controls, and permit have access to the The facility must prepermanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug districts.	State and Federal laws, the all drugs and biologicals in ints under proper temperature to only authorized personnel to keys. Ovide separately locked, decompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can	F 431		
	by: Based on observareview, the facility for were labeled as dir 26 medications obsadministration. Findings Include: On 3/28/16, at 7:50 administration was medication cart with RN-C set up and at Lantus insulin and directed by the elect Administration Recommendation Recommendation Recommendation of the set	observed from the Bayside n registered nurse (RN)-C. dministered 32 units (u) of 4 u of Humulin insulin as		The facility applied a label change to insulin bottle on 3-28-2016. Requestabel change was faxed to the pharman The facility applied a label change to Tylenol bottle on 3-30-2016. Requestabel change was faxed to the pharman The facility immediately reviewed all EMAR Medication sheets to the current medications to ensure that all labels correctly labeled for use. If any med label was found to be incorrect, and change label was applied and requestated to the pharmacy for a correct medication card/bottle. All newly admitted resident will have audit completed to ensure that all	t for a macy. OR 22 st for a macy. of the rent were ication order est

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLET				
		245258	B. WING		03/:	31/2016
	PROVIDER OR SUPPLIER SCAN HEALTH CENT		:	STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	directed to inject 2' day. The Humalog inject 5 u sq as directed to year as directed to year as directed to year as ordered three 10:30 a.m. and 4:33/17/16. Sliding sc 4 u if the blood gluglucose at the time On 3/28/16, at 7:55 on the insulin bottle order on the EMAF order had changed did not match the Ephysician order in pharmacy if a new On 3/30/16, at 8:54 administration was medication cart wit (LPN)-A. LPN-A se 500 milligrams (months and year an	7 u subcutaneous (sq) every insulin bottle label directed to ected. der Sheet indicated the Lantus insulin 32 u sq once a n 3/10/16. The Humulin insulin times a day sq at 7:30 a.m., 10 p.m. per sliding scale on ale instructions included to give cose was 150-199. R41's blood of administration was 170. 5 a.m. RN-C verified the labels es did not match the physician R. RN-C did not know if the H. The RN stated when a label EMAR she should check the the chart and notify the label was needed. 4 a.m. medication observed from the Lakeside the licensed practical nurse at up and administered Tylenol go) two tablets as directed on The label on the Tylenol bottle on mg two tablets by mouth four eded. der Sheet indicated the Tylenol 500 mg two tablets two of a.m. and 8:00 p.m. on 2/8/16. Perify the EMAR and label with	F 431	medications delivered from the plare correct with the orders in the All current residents order change audited to ensure that all medicat coming from the pharmacy are collabeled. The facility order checklist was upun add: Remove medication from more or place Order changed, see changen on medication card/bottle. All professional staff were educat person by the DON and again on 4-27-2016 or 4-28-2016 with rethe Medication Administration Polichecklist change. Audits will be completed on a rangensure correct labeling verses medicard/bottle ongoing. Results of the audits will be broug QAPI Committee for review and for recommendations. Staff Responsible: DON and Nursing Managers Completion Date: _5-6-2016	EMAR. es will be ions prrectly odated to ed/tx cart et sticker ed in view of icy and dom eek x4 to edication ght to the urther	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			X3) DATE SURVEY COMPLETED	
	245258	B. WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTE	R	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
on it indicating the o On 3/30/16, at 3:48 ((DON) stated if the r match the EMAR sh pharmacy to get the to do that they shoul would take care of it should investigate, v where the discrepan stickers stating the o The facility's Medica revised 4/6/15, indic administered withou medication had a sti directions had chang 483.70(h) SAFE/FUNCTIONAL E ENVIRON The facility must pro sanitary, and comfor residents, staff and the This REQUIREMEN by: Based on observatif failed to ensure the of and repaired to prov home-like environmen 103, 309, 311, 317) addition, the facility fequipment was mon	in bottle should have a sticker rder had changed. p.m. the director of nursing medication label did not e expected staff to call the right label. If staff was unable dinform the DON and she and the rerify the order, determine and use the order had changed. It in Administration policy ated no medication should be to a proper label. Unless, the order on it indicating the ged and to refer to the chart. L/SANITARY/COMFORTABL In it is not met as evidenced on and interview, the facility environment was monitored	F 465		where hey atched

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245258	B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER	ER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 8910 MINNESOTA AVENUE DULUTH, MN 55802	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	environmental tour, director (ESD) and verified the followin -Room 101-1 had swall behind the bed patched and had no verified painting wa painter that came in month. -Room 103 had a gwall, exposing the coutside door frame The ESD verified the surfaces and requiring and the toilet, and significant bathroom door frame are washed daily and have a schedule for the ESD stated floresident moves out ESD stated staff has the bathroom floor -Room 317 had chiroom door near the surface. The prote	ing at 11:07 a.m. during an the environmental services the corporate consultant (CC) g environmental findings: everal gouged areas in the that had been roughly of been painted. The ESD is needed and the facility had a notal certain number of hours a couged area in the bathroom dry wall and deeply gouged exposing the bare wood. Hese areas were not cleanable red repair. Indicate the deep gouges in the entry of verified the wall required area yellow stain and black aroom floor tiles around the notal chipped paint in the new the ESD stated the floors and verified the facility did not required to the routine refinishing of floors. For some are refinished when a of the room. In addition, the is not reported the condition of	F 465	Room 309 Entry way walls patch painted. Room 311 Bathroom floor refinish Room 317 Door guard replaced. areas on the edge of the door late repaired A monthly checklist for resident rebeen developed for the monitoring needed repair issues. There is also system in place for daily repair read a monthly list has been created to the painting of the rooms and the of the resident room/bathroom floall bathroom floors will be checked any staining with cleaning as need all door frames have been checked repaired and painted Door guards on all rooms have be checked to ensure the guard is or securely. Resident doors have been checked bare wood and repaired if needed Audits will be conducted in the resident wood and repaired if needed Audits will be conducted in the resident of the responsible: Environment Director, Administrator Audits will be brought to QAPI for and further recommendation Education provided to all staff on 4-27-2016 or 4-28-2016 for the unit of the repair slips and reporting when needed repair required in a reside Completion date: 5-6-2016	ned Chipped ch som has g of so a quests. track cleaning ors. ed for ded. ed, een n ed for l sident x4 and needed al review use of n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245258	B. WING		03/	31/2016	
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 465	verified it required r R45's mobility bars pipe insulation and wrapped around the verified this was no	on the bed were covered with secured with duct tape e insulation. The ESD and CC t a cleanable surface. If, the facility was unable to d procedure for routine	F 4	165			

F5258024

PRINTED: 04/28/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245258	B. WING _		03	/29/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	тѕ	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT THE PAGE OF THE CM VERIFICATION OF UPON RECEIPT CONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HACCORDANCE WALIfe Safety Code	DF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE				
	Fire Marshal Divisi Franciscan Health not in substantial c requirements for p Medicare/Medicaid 483.70(a), Life Saf edition of National	on. At the time of this survey, Center, Building 01 was found ompliance with the articipation in I at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC),				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		EPO	C	
	HEALTH CARE FIL	RE INSPECTIONS				
	STATE FIRE MAR 445 MINNESOTA ST. PAUL, MN 551	STREET, SUITE 145				

Electronically Signed

04/27/2016

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 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION : 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	245258	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	29/2016	
FRANCIS	SCAN HEALTH CENT	ER	;	3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 000	Continued From pa Marian.Whitney@s and Angela.Kappenma	state.mn.us	K 000	9.			
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or pr	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency					
	buildings: Franciscan Health building with a smalevel is all office sp The building was c The original buildin was determined to construction. In 19	Center Building 01 is a 2 story all partial basement. The 2nd acce with no resident access onstructed at 2 different times. In the 2nd be of Type II(000) an addition was constructed at 2 different times.					
	entire facility has a alarm system with	y fire sprinkler protected. The complete addressable fire smoke detection in the es open to the corridor.					
		censed capacity of 44 beds of 42 at the time of the survey.		>			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	FIPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY MPLETED
		245258	B. WING		03/	/29/2016
	PROVIDER OR SUPPLIER		۰	STREET ADDRESS, CITY, STATE, ZIP (3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 000	Continued From pa	age 2	K 0	00		
K 011 SS=D	NOT MET as evide NFPA 101 LIFE SA nonconforming but barrier having at le rating constructed addition. Commun corridors and shall self-closing fire doresistance rating 18.1.1.4.1, 18.1.1.4 19.1.1.4.2 This STANDARD Based on observarevealed that 1 of 2 not in compliance Code" 2000 edition 19.1.1.4.2, These the products of colbuilding to another 10 of 42 residents, number of staff, ar Findings include: On facility tour bet 03/29/2016, obserpenetration located through the 2 hour	a common wall with a silding, the common wall is a fire the sast a two hour fire resistance of materials as required for the icating openings occur only in the protected by approved ors with at least 1 1/2 hour fire 4.2, 18.2.3.2, 19.1.1.4.1, is not met as evidenced by: ations and staff interview, it was 2 fire separations was found with NFPA 101 "The Life Safety in (LSC) section 19.1.1.4.1 and deficient conditions could allow mbustion to travel from one to which could negatively affect, as well as an undetermined	KO	K011 In order to comply with NP will provide fire retardant careas that require a 2 hour resistance rating. The penetration located ar that is passing through the barrier in the ceiling (by the has been sealed with fire reaulking. Environmental Director has inspected the building for a have a 2 hour fire barrier to penetrations are fire stopp. The Environmental Service notify any future contractor penetrations must be prop stopped. Person responsible: Environ Service Director	aulking on all fire wall found a pipe 2 hour fire beauty shop) retardant s toured and any areas that o ensure ed. E Director will r (s) that any erly fire	5/6/16
	18.1.1.4.1, 18.1.1.4 19.1.1.4.2 This STANDARD Based on observarevealed that 1 of 2 not in compliance Code" 2000 editior 19.1.1.4.2,. These the products of colbuilding to another 10 of 42 residents, number of staff, ar Findings include: On facility tour bet 03/29/2016, obserpenetration located through the 2 hour tile over the double shop.	is not met as evidenced by: ations and staff interview, it was 2 fire separations was found with NFPA 101 "The Life Safety n (LSC) section 19.1.1.4.1 and deficient conditions could allow mbustion to travel from one r, which could negatively affect as well as an undetermined nd visitors. ween 11:30 AM to 3:30 PM on vations revealed that there is a d around a pipe that is passing fire barrier above the ceiling		In order to comply with NP will provide fire retardant c areas that require a 2 hour resistance rating. The penetration located ar that is passing through the barrier in the ceiling (by the has been sealed with fire r caulking. Environmental Director has inspected the building for a have a 2 hour fire barrier to penetrations are fire stopp. The Environmental Service notify any future contractor penetrations must be prop stopped. Person responsible: Environmental Service.	aulking on all fire wall found a pipe 2 hour fire beauty shop) retardant s toured and any areas that o ensure ed. E Director will r (s) that any erly fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245258	B, WING 0;		03/2	/29/2016	
	PROVIDER OR SUPPLIER	ER		39	TREET ADDRESS, CITY, STATE, ZIP CODE 910 MINNESOTA AVENUE OLLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Access to exits shareadily visible signs way to reach exit is occupants. Doors, not a way of exit than exit have a sign 7.10, 18.2.10.1, 19 This STANDARD is Based on observa facility has failed to non-required doors not lead to the pub NFPA 101 "The Life (LSC) sections 7.11 deficient practices residents, as well a staff, and visitors be an exit from the buevent of an emerge Findings include: On facility tour betwo 3/29/2016, observed on located in the outside that does not part of the is not labeled with a NO EXIT. The workinches in height an inch, and the word height located directions.	rvisor. AFETY CODE STANDARD all be marked by approved, in all cases where the exit or in not readily apparent to the passages or stairways that are at are likely to be mistaken for designating "No Exit". 2.10.1 is not met as evidenced by: tion and staff interview, the properly identify 1 of several is leading to the exterior that do lic way in accordance with e Safety Code" 2000 edition 0.1.7 and 7.10.8.1. These could negatively affect 42 of 42 as an undetermined number of y causing confusion in locating ilding to the public way in the ency. Ween 11:30 AM to 3:30 PM on vations revealed that the patio dinning room has a door to the not lead to a public way. This the facility's required exits and a sign that reads as follows: rd "NO" shall be in letters 2 d with a stroke width of 3/8 "EXIT" in letters 1 inch in ctly below the word "NO".		011	In order to comply with NFPA 101 Edition, sections 7.10.1.7 and 7.10 FHC will provide signage to ensure dining room door is properly labele. A sign has been posted on the pati- with labeling that reads NO EXIT I lettering consists of 2 inches in heig a stroke width of 3/8 inch Environmental Service Director has inspected all other areas of the fac- ensure compliance with NFPA 7.10 and 7.10.8.1. Person responsible: Environmental Service Director Completion date: 5-06-2016	.8.1, that d. o door he ght and s ility to	5/6/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			ATE SURVEY OMPLETED
		245258	B. WING			3/29/2016
	NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 910 MINNESOTA AVENUE ULLUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=D	Smoke barriers shalleast a one half hou constructed in accobarriers shall be per atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is Based on observating facility failed to mai barrier walls constructed in the sections 19-3.7.3 accould affect 14 of 4 undetermined nument allowing smoke to proceed the compartment to an Findings include: On facility tour betwo 3/29/2016, observe penetration found a wires that are pass barrier above the cobarrier doors that a 311.	s not met as evidenced by: tion and staff interview, the ntain 1 of several smoke uction that meet the FPA 101 - 2000 edition, and 8.3. This deficient practice 2 residents as well as an ber of staff, and visitors by propagate from one smoke	K	025	In order to comply with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2 AND 8.3.6, FHC will apply fire retardant caulking on all areas that require a 1 smoke barrier. The penetration in the ceiling by room 3 has been sealed with fire retardant caulking. Environmental Director has toured and inspected the building for any areas that require fire retardant caulking. The Environmental Service Director will notify any future contractor (s) that any penetrations must be properly fire stopped. Person responsible: Environmental Service Director Completion date 5-06-2016	11
K 052 SS=C	Maintenance Supe NFPA 101 LIFE SA A fire alarm system be, tested, and mai NFPA 70 National E National Fire Alarm			052		5/6/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245258	B. WING 03/		03/2	29/2016	
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
K 052	maintenance and to applicable requiren 9.6.1.4, 9.6.1.7, This STANDARD in Based on observa facility failed to instruction system in accordar 2000 NFPA 101, Sci 19.3.6.3.3, and 9.6 Sections 7.1. The adversely affect the system that could demergency actions affecting 42 of 42 rundetermined num facility. Findings include: On facility tour betw 03/29/2016, observe of all availated alarm maintenance last 12 months and Maintenance Superfacility failed to door applicable services of all availated alarm maintenance Superfacility failed to door applicable services and services are services are services and services are services and services are services are services are services are services and services are services are services and services are services are services and services are services	esting program complying with nent of NFPA 70 and 72. s not met as evidenced by: tion and staff interview, the all and maintain the fire alarmace with the requirements of ections 19.3.4., 19.3.6.3.2, as well as 1999 NFPA 72, se deficient practices could a functioning of the fire alarmatelay the timely notification and for the facility thus negatively esidents as well as an ber of staff, and visitors to the veen 11:30 AM to 3:30 PM on vations revealed that during the ple fire drill reports and fire extesting documentation for the lan interview with the rvisor, it was revealed that the sument and/or verify 1 of 12 edigital alarm communicator	K 08	In order to comply with NFF edition, sections 19.3.4 and well as NFPA 72 Section 7.1 Environmental Service Direct perform monthly tests of the communicator transmitter. The fire alarm drill reports a maintenance testing documbe in place and available to administrator to monitor for The Environmental Service ensure that fire drills conduct non-business hours will include digital alarm communicates Person responsible: Environ Service Director Completion date: 5-06-2016	19.3.6.3.2 as the ctor will edigital alarm alarm entation will the compliance. Director will cted during ude tests of ator.		
K 056 SS=D	Maintenance Supe NFPA 101 LIFE SA Where required by facilities shall be pr approved, supervis in accordance with systems are equip	ition was verified by a rvisor. FETY CODE STANDARD section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system section 9.7. Required sprinkler ped with water flow and tamper electrically interconnected to	K 0:	56		5/6/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245258	B, WING		03/2	29/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 056	construction, altern shall be permitted protection in speci regulations prohibit NPFA 13 This STANDARD Based on observations accordance with NInstallation of Sprinthe failure to main compliance with N being place out of the fire protection of an emergency thresidents, as well staff, and visitors. Findings include: On facility tour bet 03/29/2016, obser deficient conditions sprinkler system: 1. The current spain the care center spares of every typlocated throughout 2. The sprinkler griser assembly have replaced within the	arm. In Type I and II mative protection measures to be substituted for sprinkler fic areas where State or local at sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: ations, the automatic sprinkler alled and maintained in IAPA 13 the Standard for the nkler Systems 1999 edition. Atain the sprinkler system in APA 13 (99) could allow system service causing a decrease in system capability in the event hat could affect 42 of 42 as an undetermined number of ween 11:30 AM to 3:30 PM on vations reveled the following affecting the facility's fire are sprinkler head box located did not contain at least two be and style of sprinkler head at the facility. auges located at the primary we not been re-calibrated or a last 5 years.	K 056	In order to comply with NFPA 10 edition sections 19.3.5 and 19.3. NAPA 13 (99), FHC will have in the required amount of spare sprheads. The facility sprinkler vendor has the facility with two of each type of sprinkler heads found in the facility. The facility sprinkler vendor has the sprinkler gauge located at the riser with a pressure gauge ¿ incogauge valve. The Environmental Services dire maintain replacement/re-calibratic records for the sprinkler gauges, as the number of spare sprinkler located in the facility. Person responsible: Environment Service Director	5.1 and ne facility, inkler supplied of ty. replaced e primary h 3 way ctor will on as well heads	
K 062		AFETY CODE STANDARD	K 06			5/6/16

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245258	B. WING _		03/	29/2016
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 3910 MINNESOTA AVENUE DULUTH, MN 55802	ΡΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 062 SS=C	Required automatic continuously maint condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on docume with staff, the facility and maintain the areaccordance with NI Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire If deficient practice disprinkler system is fully operational in negatively affect 42 undetermined numfacility. Findings include: On facility tour betwo 3/29/2016, a revieinterview with the revealed that at the facility could not prince the periodic and the system is fully operational in the system is fully operati	esprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, so not met as evidenced by: notation review and interview by has failed to properly inspect automatic sprinkler system in FPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could 2 of 42 residents as well as an ber of staff, and visitors to the event of the inspection the ovide any documentation for 2 prinkler flow test having been	K 06	In order to comply with NFPA edition, section 19.7.6 and 4.6 NFPA 13, NFPA 25, section 9 ensure the Automatic Sprinkle will be properly inspected and The facility sprinkler vendor of flow test on 3-17-2016. The Environmental Service Diconduct the other quarterly fir flow tests, and maintain documental the testing was complete Responsible person: Environ Service Director Completion date: 5-06-16	3.12 and .7.5 FHC will er System maintained. onducted a irector will e sprinkler mentation d.	
K 104 SS=D	This deficient cond Maintenance Supe NFPA 101 LIFE SA Penetrations of sm	lition was verified by a rvisor. FETY CODE STANDARD oke barriers by ducts are dance with 8.3.5. Dampers are	K 10	04		5/6/16

Facility ID: 00865

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245258	B. WING		03/	29/2016
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COI 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 104	barriers in fully due sprinkler system in provided for adjace 18.3.7.3, 19.3.7.3. damper testing into NFPA 105. All other maintain a 4-year of 8.3.5. This STANDARD Based on docume interview, the fire/s been maintained in requirements of NF 5.2. This deficient proper operation of could allow smoke 42 of 42 residents number of staff, and Findings include: On facility tour betwo 3/29/2016 it was the facility's fire and test/inspection documentation ver dampers has been last 4 years.	t penetrations of smoke atted HVAC systems where a accordance with 18/19.3.5 is ent smoke compartments. Hospitals may apply a 6-year erval conforming to NFPA 80 & a health care facilities must damper maintenance interval. The sistens of the service of the servi	K 104	In order to comply with NFPA edition, section 8.3.5 and NFI Section 5.1.2 and 5.2 FHC w Fire/Smoke Dampers are tes inspected every 4 years. Facility does not have smoke HVAC System shuts down at upon activation of the fire ala has approved supervised aut sprinkler system in accordant 19.3.5.3 Environmental Service Direct maintain the quarterly testing sprinkler system. Responsible person: Environ Service Director Completion date: 5-06-16	PA 90 (99) ill ensure that ted or dampers. utomatically rm. Facility comatic ce with etor will of the	
K 144 SS=D	Maintenance Supe NFPA 101 LIFE SA Generators inspec		K 14	4		5/6/16

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
	a	245258	B. WING	·	03/2	29/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 144	3-4.4.1 and 8-4.2 (110) This STANDARD Based on docume interview, the facilithe emergency gerequirements of the Code" 2000 editior 1999 NFPA 110 6-deficient practice of staff, and visitors in Findings include: On facility tour beth 03/29/2016, observated in the supply did criteria: 1. a statement of matural gas deliver 2. a brief description regarding the relial 3. a statement that interruption of the 4. a brief description regarding the low present the supply did criterial that interruption of the 4. a brief description regarding the low present the supply did criterial that interruption of the 4. a brief description regarding the low present that interruption is the low present that interruption of the 4. a brief description regarding the low present that interruption is the low present that the supplementary is the supplementary that the supplementary is the supplementary in the supplementary is	is not met as evidenced by: entation review and staff ty failed to test and maintain herator in accordance with the e NFPA 101 "The Life Safety in (LSC) sections, 9.1.3 and 4, 6-4.1, and 6-4.2.2. The could affect 75 of 75 residents, in the event of an emergency. ween 11:30 AM to 3:30 PM on vations revealed that the diable service for their natural is not provide the following reasonable reliability of the y on that supports the statement bility at there is a low probability of natural gas on that supports the statement probability of interruption	K 144	In order to comply with NFPA 10 Edition, sections 9.1.3 and 1999 110 6-4, 6-4,1 and 6-4.2.2, FHC ensure that the facility has in place that provides the following: A letter will be obtained from the Duluth Gas Department that included 1. Statement of reasonable reliations the natural gas delivery 2. A brief description that suppostatement that supports the state regarding the reliability 3. A statement that there is a loprobability of interruption of the natural gas 4. A brief description that suppostatement regarding the low probability of interruption that suppostatement regarding the low probability compliance with K1444 Responsible person: Environment Service Director Completion date: 5-06-2016	NFPA will ce a letter City of udes: ability of orts the ment w atural orts the ability of	

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - FRANCISCAN HEATLH CENTER 245258 B. WING 03/29/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3910 MINNESOTA AVENUE FRANCISCAN HEALTH CENTER **DULUTH, MN 55802** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Franciscan Health Center, Building 02 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

Electronically Signed

04/27/2016

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG 02 - FRANCISCAN HEATLH CENTER	COMPLETED
		245258	B. WING_		03/29/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIC
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or p 3. The name and/oresponsible for con-	state.mn.us n@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	K 00	20	
	buildings: Franciscan Health addition and is a d basement. The co determined to be o properly fire separ hour fire separatio This building is full entire facility has a alarm system with corridors and space	Center Building 02 is a 2006 one (1) story building with no onstruction type was of Type II(000). Building 02 is ated from building 01 by a 2 n. By fire sprinkler protected. The a complete addressable fire smoke detection in the ces open to the corridor. Sicensed capacity of 44 beds of 42 at the time of the survey.			

PRINTED: 04/28/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 02 - FRANCISCAN HEATLH CENTER 245258 B. WING 03/29/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3910 MINNESOTA AVENUE FRANCISCAN HEALTH CENTER **DULUTH, MN 55802** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 2 K 000 The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by: K 052 NFPA 101 LIFE SAFETY CODE STANDARD K 052 5/6/16 SS=C A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: In order to comply with NFPA 101 [] 2000 Based on observation and staff interview, the edition, sections 19.3.4 and 19.3.6.3.2 as facility failed to install and maintain the fire alarm well as NFPA 72 Section 7.1, the system in accordance with the requirements of **Environmental Service Director will** 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, perform monthly tests of the digital alarm 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, communicator transmitter. Sections 7.1. These deficient practices could The fire alarm drill reports and alarm adversely affect the functioning of the fire alarm maintenance testing documentation will system that could delay the timely notification and emergency actions for the facility thus negatively be in place and available to the affecting 42 of 42 residents as well as an administrator to monitor for compliance. The Environmental Service Director will undetermined number of staff, and visitors to the ensure that fire drills conducted during facility. non-business hours will include tests of the digital alarm communicator. Findings include: Person responsible: Environmental Service Director On facility tour between 11:30 AM to 3:30 PM on Completion date: 5-06-2016 03/29/2016, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 1 of 12 monthly tests of the digital alarm communicator transmitter (DACT).

REGULATORY OR LSC IDENTIFYING INFORMATION) K 052 Continued From page 3 This deficient condition was verified by a Maintenance Supervisor. K 056 SS=D There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler rotection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. K 052 K 056 K 056 K 056 K 056 K 056 K 056 S=D There is an automatic sprinkler system installed in accordance with NFPA 13, standard for the larght and the provide complete coverage of all portions of the facility. The facility sprinkler vendor will supply the facility sprinkler vendor will supply the facility sprinkler vendor will supply the facility sprinkler used found in the facility. The facility sprinkler vendor has replaced the sprinkler gauge located at the primary riser with a pressure gauge ¿ inch 3 way		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X 02 - FRANCISCAN HEATLH CENTER		SURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802			245258	B. WING			03/2	29/2016
K 052 Continued From page 3 This deficient condition was verified by a Maintenance Supervisor. K 056 NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. K 052 K 055 K 056 K 056 SS=D In order to comply with NFPA 101 2000 edition sections 19.3.5 and 19.3.5.1 and NAPA 13 (99), FHC will have in the facility, the required amount of spare sprinkler heads. The facility sprinkler vendor will supply the facility with two of each type of sprinkler heads found in the facility. The facility sprinkler vendor has replaced the sprinkler gauge located at the primary riser with a pressure gauge ξ inch 3 way					39	910 MINNESOTA AVENUE		
This deficient condition was verified by a Maintenance Supervisor. K 056 SS=D There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5, 1. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. K 056 5/6// K 056 5/6// K 056 5/6// In order to comply with NFPA 101 2000 edition sections 19.3.5 and 19.3.5.1 and NAPA 13 (99), FHC will have in the facility, the required amount of spare sprinkler heads. The facility sprinkler vendor will supply the facility with two of each type of sprinkler heads found in the facility. The facility sprinkler vendor has replaced the sprinkler gauge located at the primary riser with a pressure gauge ¿ inch 3 way	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: The Environmental Services director will maintain replacement/re-calibration records for the sprinkler gauges, as well as the number of spare sprinkler heads located in the facility. Person responsible: Environmental Service Director Completion Date: 5-06-2016	K 056	This deficient cond Maintenance Super NFPA 101 LIFE SATE There is an automin accordance with Installation of Sprin components, device complete coverage Systems are equip switches, which an system. In Type I a protection measure substituted for sprin areas where State sprinklers. 18.3.5, This STANDARD Based on observations accordance with N Installation of Sprin The failure to main compliance with N being place out of the fire protection of an emergency thresidents, as well a staff, and visitors. Findings include: On facility tour betto 03/29/2016, observed ficient conditions sprinkler system: 1. The current spare.	dition was verified by a servisor. AFETY CODE STANDARD atic sprinkler system installed a NFPA13, Standard for the nkler Systems, with approved the end equipment, to provide the of all portions of the facility. Sped with waterflow and tamper the connected to the fire alarm and II construction, alternative the estable permitted to be nkler protection in specific or local regulations prohibit 18.3.5.1. Is not met as evidenced by: Ations, the automatic sprinkler alled and maintained in 18.7 and 13 the Standard for the nkler Systems 1999 edition. In the sprinkler system in 1990 could allow system service causing a decrease in system capability in the event that could affect 42 of 42 as an undetermined number of 11.30 AM to 3:30 PM on vations reveled the following affecting the facility's fire			edition sections 19.3.5 and 19.3.5.1 a NAPA 13 (99), FHC will have in the father required amount of spare sprinkle heads. The facility sprinkler vendor will supp facility with two of each type of sprink heads found in the facility. The facility sprinkler vendor has replathe sprinkler gauge located at the pririser with a pressure gauge ¿ inch 3 gauge valve. The Environmental Services director maintain replacement/re-calibration records for the sprinkler gauges, as a sthe number of spare sprinkler head located in the facility. Person responsible: Environmental Service Director	and acility, er bly the kler aced imary way r will well	5/6/16

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		3) DATE SURVEY COMPLETED
	245258	B. WING		03/29/2016
OVIDER OR SUPPLIER	ER		3910 MINNESOTA AVENUE	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		
ocated throughout The sprinkler gainser assembly hav	the facility. auges located at the primary e not been re-calibrated or	K 056		
Maintenance Super NFPA 101 LIFE SA Automatic sprinkle maintained in relial nspected and test 4.6.12, NFPA 13, NThis STANDARD Based on docume with staff, the facility and maintain the accordance with NS Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire deficient practice of sprinkler system is fully operational in negatively affect 42 undetermined numfacility. Findings include: On facility tour better the property of the system is fully operational in the system is fully op	ryisor. AFETY CODE STANDARD r systems are continuously ble operating condition and are ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 is not met as evidenced by: entation review and interview ty has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation ins (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This loes not ensure that the fire functioning properly and is the event of a fire and could 2 of 42 residents as well as an other of staff, and visitors to the lower 11:30 AM to 3:30 PM on	K 062	In order to comply with NFPA 101 dedition, section 19.7.6 and 4.6.12 an NFPA 13, NFPA 25, section 9.7.5 Feensure the Automatic Sprinkler Systewill be properly inspected and mainta. The facility sprinkler vendor conduct flow test on 3-17-2016. The Environmental Service Director conduct the other quarterly fire sprin flow tests, and maintain documentat that the testing was completed.	d C will em ained. ed a will kler ion
	OVIDER OR SUPPLIER SAN HEALTH CENT SUMMARY STA (EACH DEFICIENC) REGULATORY OR LE Continued From particle of the sprinkler gassembly have replaced within the state of the sprinkle maintained in relial magnetic and tested and tested and tested and tested and tested and maintained in relial magnetic and maintain the and cordance with N Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire Inspection, water Based Fire Inspection al in magnetic sprinkler system is fully operational in the sprinkler system is fully op	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 ocated throughout the facility. C. The sprinkler gauges located at the primary iser assembly have not been re-calibrated or replaced within the last 5 years. This deficient condition was verified by the Maintenance Supervisor. NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility.	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 ocated throughout the facility. 2. The sprinkler gauges located at the primary iser assembly have not been re-calibrated or eplaced within the last 5 years. This deficient condition was verified by the Maintenance Supervisor. NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are nspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, a review of documentation and nterview with the Maintenance Supervisor	A BUILDING 02 - FRANCISCAN HEATLH CENTER 245258 STREET ADDRESS, CITY, STATE, ZIP CODE 310 MINNESOTA AVENUE DULUTH, MN 55802 SUMMARY STATEMENT OF DESIGNOISS (EACH DEFICIENCY) MINST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Cocated throughout the facility. 2. The sprinkler gauges located at the primary iser assembly have not been re-calibrated or eplaced within the last 5 years. If his deficient condition was verified by the Maintenance Supervisor. VEPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are nespected and tested periodically. 18.7.6, 19.7.6, 16.12, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is utily operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the adultity. Difficulty of the facility of the definition of the properly inspected and maintain the tested periodically affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the adultity operational in the event of a fire and could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the adultity of the property of the property of the property of the very started property of the property o

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From p completed.	age 5 dition was verified by a	K 062			
K 104 SS=D	Maintenance Supe NFPA 101 LIFE SA Penetrations of sn protected in accor not required in duc barriers in fully du sprinkler system in provided for adjac 18.3.7.3, 19.3.7.3. damper testing int NFPA 105. All other maintain a 4-year 8.3.5 This STANDARD Based on docume interview, the fire/si been maintained i requirements of N 5.2. This deficient proper operation of could allow smoke 42 of 42 residents number of staff, and Findings include: On facility tour bef 03/29/2016, it was the facility's fire ar test/inspection do by interview with to that the facility had documentation ve	arvisor. AFETY CODE STANDARD noke barriers by ducts are dance with 8.3.5. Dampers are ct penetrations of smoke cted HVAC systems where a n accordance with 18/19.3.5 is ent smoke compartments. Hospitals may apply a 6-year erval conforming to NFPA 80 & er health care facilities must damper maintenance interval. is not met as evidenced by: entation review and staff smoke damper system has not n accordance with the FPA 90(99) section 5-1.2 and practice does not ensure the of the fire/smoke dampers and e migration to negatively affect as well as an undetermined nd visitors to the facility. Atween 11:30 AM to 3:30 PM on a revealed during the review of nd smoke damper cumentation and was confirmed the Maintenance Supervisor,	K 104	In order to comply with NFPA 101 edition, section 8.3.5 and NFPA 90 Section 5.1.2 and 5.2 FHC will ens Fire/Smoke Dampers are tested or inspected every 4 years. The Facility HVAC Contractor has completed the fire and damper tes inspection and will be scheduled to routine checks every 4 years as re The Environmental Services Direct maintain documentation on the test and inspecting of the Fire/Smoke Dampers to ensure compliance with K104. Responsible person: Environmental Service Director	2000 (99) ure that do the quired. tor will ting	5/6/16

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION . 12 - FRANCISCAN HEATLH CENTER	(X3) DATE COMF	SURVEY
		245258	B. WING			03/2	9/2016
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER				39	REET ADDRESS, CITY, STATE, ZIP CODE 10 MINNESOTA AVENUE ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 104	Continued From palast 4 years. This deficient cond	age 6 lition was verified by the	K 1	04			
K 144 SS=D	Maintenance Super NFPA 101 LIFE SA Generators inspect under load for 30 r in accordance with 3-4.4.1 and 8-4.2 (110) This STANDARD Based on docume interview, the facility the emergency generequirements of the Code" 2000 edition 1999 NFPA 110 6-deficient practice of staff, and visitors in Findings include: On facility tour bet 03/29/2016, obsert facility's letter of regas fuel supply discriteria: 1. a statement of natural gas deliver 2. a brief descript regarding the relia 3. a statement that interruption of the 4. a brief descript	ted weekly and exercised minutes per month and shall be in NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by: entation review and staff try failed to test and maintain merator in accordance with the en NFPA 101 "The Life Safety in (LSC) sections, 9.1.3 and 4, 6-4.1, and 6-4.2.2. The could affect 75 of 75 residents, in the event of an emergency. Ween 11:30 AM to 3:30 PM on vations revealed that the eliable service for their natural I not provide the following reasonable reliability of the typon that supports the statement bility at there is a low probability of	K	144	In order to comply with NFPA 101 Edition, sections 9.1.3 and 1999 N 6-4, 6-4,1 and 6-4.2.2, FHC will e that the facility has in place a lette provides the following: A letter will be obtained from the CDuluth Gas Department that included. Statement of reasonable reliating the natural gas delivery 2. A brief description that supports the statement that supports the statement that supports the statement regarding the reliability 3. A statement that there is a low probability of interruption of the natural gas 4. A brief description that supports the statement regarding the low probability of interruption This letter will be kept on file at the to verify compliance with K1444 Responsible person: Environment Service Director Completion date: 5-06-2016	FPA 110 nsure r that city of des: bility of ts the nent r tural ts the ability of	5/6/16

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

Facility ID: 00865

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 02 - FRANCISCAN HEATLH CENTER	1 00	TE SURVEY MPLETED	
		245258	B. WING		03/29		
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
K 144	Continued From p This deficient cond Maintenance Supe	dition was verified by the	K 1	144			