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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X4ZT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00865

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/09/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Chris Campbell, HFE NEII 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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 Meath

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

MDH
Minnesota Department of Health

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245258 Y1	A. Building B. Wing Y2	5/9/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0369	Correction	ID Prefix F0431	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.35(g)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	05/06/2016	LSC	05/06/2016	LSC	05/06/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/06/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	CC/mm	05/23/2016	13922	05/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/31/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245258 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/9/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	05/06/2016	LSC K0022	05/06/2016	LSC K0025	05/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0104	05/06/2016	LSC K0144	05/06/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	05/23/2016	27200	05/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/29/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245258 Y1	A. Building 02 - FRANCISCAN HEATLH CENTER B. Wing Y2	5/9/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
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
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0104	05/06/2016	LSC	K0144	05/06/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	05/23/2016	27200	05/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/29/2016

☐ 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: X4ZT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00865

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/31/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 04/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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.

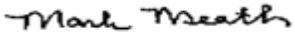
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	03/31/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for adaptive equipment to aid in independent eating for 1 of 3 residents (R26) reviewed for nutrition. Findings include: R26's admission record dated 12/30/16, indicated diagnoses that included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke). R26's significant change MDS dated 2/23/16,	F 282	Resident 26 was assessed by nursing/dietary assessment for use of the (scoop plate) adaptive equipment per his 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-assessed by OT for the need of current adaptive equipment. All care plans will be reviewed and updated prn for residents who did meet the need for adaptive equipment.	5/6/16

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

Electronically Signed | 04/22/2016

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F 282	Continued From page 1 indicated R26 required supervision with eating to include oversight, encouragement or cueing. R26's 2/25/16, nutritional status Care Area Assessment (CAA) indicated R26 was able to feed himself after some set up with adaptive equipment. R26's 12/30/15, nutrition/eating care plan indicated R26 was at risk for weight loss and used adaptive equipment. The goal was to prevent weight loss. The care plan directed staff to provide adaptive eating equipment, specifically a scoop plate and to provide supervision with eating. On 3/29/16, at 4:40 p.m. R26 was observed at a dining room table. R26 was eating mashed potatoes and green beans with a fork. R26 did not have a scoop plate, but was eating on a regular ceramic plate. On 3/30/16, at 11:02 a.m. R26 was observed eating biscuits and gravy and scrambled eggs. R26 did not have a scoop plate, but was eating on a regular ceramic plate. R26 did not have the biscuit cut and did not eat the biscuit, although he was observed to eat approximately 25% of the gravy. R26 was observed to attempt to pull at pieces of the biscuit with his fork without success. R26 at 100% of his scrambled eggs. Although staff encouraged R26 to drink his fluids, there was no assistance offered to cut up his biscuit or obtain the necessary adaptive equipment. On 3/30/16, at 11:54 a.m. the dietary manager (DM) stated she has not audited for adaptive equipment implementation and did not know how the kitchen staff was unaware of the scoop plate needed for R26. His name was on the list and the	F 282	All current residents moving forward and newly admitted residents once the assessment for need of adaptive equipment is determined by OT will have their care plan updated for the use of such equipment. All staff who serve resident meals were re-educated regarding the importance of providing adaptive equipment per the care plan and/or reading meal tickets during meal pass. Daily audits of resident use of their adaptive equipment will be completed at least 2x daily for 3 weeks, then 3x a week x4 to ensure compliance. If compliance is met random audits will be continued on a weekly basis. Results of audits will be brought back to the QAPI Committee for review and any additional recommendations. Education held on 4-27- 2016 or 4-28-2016 for all staff Responsible staff: DON, Dietary Manager, Nurse Managers and Administrator Completion date:___5-6-2016_____	

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F 282	Continued From page 2 scoop plate was listed on his tray card.	F 282		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement adaptive equipment to aid in independent eating for 1 of 3 residents (R26) reviewed for nutrition. Findings include: R26's admission record dated 12/30/16, indicated diagnoses that included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke). Other diagnoses listed included depression, right shoulder pain, hypertension, heart disease, peripheral vascular disease and headaches. R26's admission Minimum Data Set (MDS) dated 1/6/16, indicated he needed extensive assistance with many activities of daily living (ADLs), including dressing, toileting, and transfers, but was independent with eating after set-up. The significant change MDS dated 2/23/16, indicated R26 required supervision with eating to include oversight, encouragement or cueing. R26's 2/25/16, nutritional status Care Area Assessment (CAA) indicated R26 was able to feed himself after some set up with adaptive equipment.	F 369	Resident 26 was assessed for the need of adaptive equipment with the following change: Adaptive equipment discontinued All residents who use adaptive equipment will be re-assessed by OT to ensure the need for the use of adaptive equipment. All newly admitted residents and current residents will continue to be audited for the use/need of the adaptive equipment. All staff who serve resident meals were re-educated regarding the importance of providing adaptive equipment per the care plan and/or reading meal tickets during meal pass. Daily audits of resident use of their adaptive equipment will be completed at least 2 x daily for 3 weeks, then 3x a week x4 to ensure compliance. If compliance is met random audits will be continued on a weekly basis. Education held on 4-27- 2016 or 4-28-2016 for all staff Results of audits will be brought back to the QAPI Committee for review and any additional recommendations. Responsible staff: DON, Dietary Manager, Nurse Managers and Administrator Completion date: 5-6-2016	5/6/16

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F 369	Continued From page 3	F 369		

R26's 12/30/15, nutrition/eating care plan indicated R26 was at risk for weight loss and used adaptive equipment. The goal was to prevent weight loss. The care plan directed staff to provide adaptive eating equipment, specifically a scoop plate and supervision with eating.

The 1/5/16, dietary progress noted indicated R26 was admitted on a regular mechanical soft diet with thin liquids. R26 was given a scoop plate at meal time due to his stroke.

The 1/7/16, dietary progress note indicted R26's admission weight was 143 pounds and this was under R26's usual stated weight of 150 pounds. The note indicated that family confirmed this weight history at a care conference.

The 3/23/16, dietary progress note indicated R26's current weight was 134 pounds which was indicative of significant weight loss (greater than 5% of body weight).

Observation of R26's tray card, the kitchen's "cheat sheet" for adaptive equipment and the nutritional care plan summary sheet revealed R26 was to receive food on a scoop plate to assist with independent eating.

On 3/29/16, at 4:40 p.m. R26 was observed at a dining room table with two other residents. R26 was eating mashed potatoes and green beans with a fork. R26 did not have a scoop plate, but was eating on a regular ceramic plate. R26 ate approximately 80% of his meal.

On 3/30/16, at 11:02 a.m. R26 was observed eating biscuits and gravy and scrambled eggs. R26 did not have a scoop plate, but was eating

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F 369	Continued From page 4	F 369		

on a regular ceramic plate. R26 did not have the biscuit cut and did not eat the biscuit, although he was observed to eat approximately 25% of the gravy. R26 was observed to attempt to pull at pieces of the biscuit with his fork without success. R26 at 100% of his scrambled eggs. Although staff encouraged R26 to drink his fluids, there was no assistance offered to cut up his biscuit or obtain the necessary adaptive equipment.

On 3/30/16, at 11:48 a.m. cook (C)-A stated adaptive equipment was on R26's tray card, the nutritional care plan summary sheet in the service area and the "cheat sheet" by the service counter. C-A stated these are reviewed weekly unless there was a change in between. When asked if R26 used any adaptive equipment C-A stated he did not. When R26's name was pointed out on the lists, C-A stated she was not aware that R26 was to receive a scooped plate.

On 3/30/16, at 11:51 a.m. C-B stated she did not know R26's name was on the nutritional care plan summary sheet, the cheat sheet or the tray card.

On 3/30/16, at 11:54 a.m. the dietary manager (DM) stated adaptive equipment was indicated on a resident's tray ticket and they kept a list as well. If there was a new addition a dietary communication slip was used to communicate changes to the full kitchen staff. The DM stated she has not audited for adaptive equipment implementation and does not know how the kitchen staff was unaware of the scoop plate needed for R26. DM confirmed R26's name was on the list and the scoop plate was listed on his tray card.

On 3/30/16, at 3:13 p.m. occupational therapist

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F 369	Continued From page 5 (OT)-C stated therapy was informed R26 was assessed by facility staff to not need assistance with eating, so they had not done a therapy evaluation. On 3/31/16, at 9:37 a.m. the director of nursing (DON) stated anybody can see a resident struggling and provide adaptive eating equipment. The DON stated they try to get occupational therapy orders, but nursing can also implement an intervention. On 3/31/16, at 9:45 a.m. the DM stated it is appropriate for dietary staff to see something may be needed for a resident and use it for that resident. The DM stated typically an occupational therapy assessment would follow. The DM stated she could not explain why this did not happen for R26. A policy on adaptive equipment implementation was requested but not received.	F 369		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		5/6/16

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F 431	Continued From page 6 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled as directed by the physician for 3 of 26 medications observed for medication administration. Findings Include: On 3/28/16, at 7:50 a.m. medication administration was observed from the Bayside medication cart with registered nurse (RN)-C. RN-C set up and administered 32 units (u) of Lantus insulin and 4 u of Humulin insulin as directed by the electronic Medication Administration Record (EMAR) to R41. The medication label on the Lantus insulin bottle	F 431	The facility applied a label change to R41 insulin bottle on 3-28-2016. Request for a label change was faxed to the pharmacy. The facility applied a label change to R 22 Tylenol bottle on 3-30-2016. Request for a label change was faxed to the pharmacy. The facility immediately reviewed all of the EMAR Medication sheets to the current medications to ensure that all labels were correctly labeled for use. If any medication label was found to be incorrect, an order change label was applied and request faxed to the pharmacy for a correct medication card/bottle. All newly admitted resident will have an audit completed to ensure that all	

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F 431	Continued From page 7 directed to inject 27 u subcutaneous (sq) every day. The Humalog insulin bottle label directed to inject 5 u sq as directed. The Physicians Order Sheet indicated the physician ordered Lantus insulin 32 u sq once a day at 8:00 a.m. on 3/10/16. The Humulin insulin was ordered three times a day sq at 7:30 a.m., 10:30 a.m. and 4:30 p.m. per sliding scale on 3/17/16. Sliding scale instructions included to give 4 u if the blood glucose was 150-199. R41's blood glucose at the time of administration was 170. On 3/28/16, at 7:55 a.m. RN-C verified the labels on the insulin bottles did not match the physician order on the EMAR. RN-C did not know if the order had changed. The RN stated when a label did not match the EMAR she should check the physician order in the chart and notify the pharmacy if a new label was needed. On 3/30/16, at 8:54 a.m. medication administration was observed from the Lakeside medication cart with licensed practical nurse (LPN)-A. LPN-A set up and administered Tylenol 500 milligrams (mg) two tablets as directed on the EMAR to R22. The label on the Tylenol bottle directed to give 500 mg two tablets by mouth four times a day as needed. The Physicians Order Sheet indicated the physician ordered Tylenol 500 mg two tablets two times a day at 8:00 a.m. and 8:00 p.m. on 2/8/16. The LPN did not verify the EMAR and label with the physician order in the chart. On 3/30/2016, at 9:00 a.m. LPN-A verified the label on the medication bottle did not match the directions on the EMAR and she did not verify with the physician order in the chart. The LPN	F 431	medications delivered from the pharmacy are correct with the orders in the EMAR. All current residents order changes will be audited to ensure that all medications coming from the pharmacy are correctly labeled. The facility order checklist was updated to add: Remove medication from med/tx cart or place Order changed, see chart sticker on medication card/bottle. All professional staff were educated in person by the DON and again on 4-27-2016 or 4-28-2016 with review of the Medication Administration Policy and checklist change. Audits will be completed on a random basis 3x a week x 4, then 2x a week x4 to ensure correct labeling verses medication card/bottle ongoing. Results of the audits will be brought to the QAPI Committee for review and further recommendations. Staff Responsible: DON and Nurse Managers Completion Date: _5-6-2016_____	

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F 431	Continued From page 8 stated the medication bottle should have a sticker on it indicating the order had changed. On 3/30/16, at 3:48 p.m. the director of nursing (DON) stated if the medication label did not match the EMAR she expected staff to call the pharmacy to get the right label. If staff was unable to do that they should inform the DON and she would take care of it. The DON further stated staff should investigate, verify the order, determine where the discrepancy came from and use the stickers stating the order had changed. The facility's Medication Administration policy revised 4/6/15, indicated no medication should be administered without a proper label. Unless, the medication had a sticker on it indicating the directions had changed and to refer to the chart.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was monitored and repaired to provide a cleanable and home-like environment in 5 of 30 rooms (101-1, 103, 309, 311, 317) reviewed for environment. In addition, the facility failed to ensure resident care equipment was monitored and repaired for 1 of 30 residents (R45) reviewed for environment.	F 465	The facility immediately removed the sponge tubes on R45 mobility bars. All other mobility rails in the facility where checked to ensure that if covered they have washable ability. Room 101-1- gouges behind bed patched and painted Room 103- gouge area in the bathroom, door frame patched and painted	5/6/16

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F 465	Continued From page 9 Findings include: On 3/30/16, beginning at 11:07 a.m. during an environmental tour, the environmental services director (ESD) and the corporate consultant (CC) verified the following environmental findings: -Room 101-1 had several gouged areas in the wall behind the bed that had been roughly patched and had not been painted. The ESD verified painting was needed and the facility had a painter that came in a certain number of hours a month. -Room 103 had a gouged area in the bathroom wall, exposing the dry wall and deeply gouged outside door frame, exposing the bare wood. The ESD verified these areas were not cleanable surfaces and required repair. -Room 309 had had deep gouges in the entry way wall. The ESD verified the wall required repair. -Room 311 had a large yellow stain and black marring on the bathroom floor tiles around the toilet, and significant chipped paint in the bathroom door frame. The ESD stated the floors are washed daily and verified the facility did not have a schedule for routine refinishing of floors. The ESD stated floors are refinished when a resident moves out of the room. In addition, the ESD stated staff has not reported the condition of the bathroom floor to him. -Room 317 had chipped areas on the edge of the room door near the latch, creating a rough surface. The protective cover at the bottom of the door was cracked and pulling away. The ESD	F 465	Room 309 Entry way walls patched and painted. Room 311 Bathroom floor refinished Room 317 Door guard replaced. Chipped areas on the edge of the door latch repaired A monthly checklist for resident room has been developed for the monitoring of needed repair issues. There is also a system in place for daily repair requests. A monthly list has been created to track the painting of the rooms and the cleaning of the resident room/bathroom floors. All bathroom floors will be checked for any staining with cleaning as needed. All door frames have been checked, repaired and painted Door guards on all rooms have been checked to ensure the guard is on securely. Resident doors have been checked for bare wood and repaired if needed Audits will be conducted in the resident room 3x a week x 3, then weekly x4 and monthly thereafter. Repairs when needed will be done in a timely manner. Person responsible: Environmental Director, Administrator Audits will be brought to QAPI for review and further recommendation Education provided to all staff on 4-27-2016 or 4-28-2016 for the use of the repair slips and reporting when needed repair required in a resident room Completion date: 5-6-2016	

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F 465	Continued From page 10 verified it required repair. R45's mobility bars on the bed were covered with pipe insulation and secured with duct tape wrapped around the insulation. The ESD and CC verified this was not a cleanable surface. Although requested, the facility was unable to provide a policy and procedure for routine monitoring and maintenance.	F 465		

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	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/29/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 01 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 19 Existing 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:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 2 separate buildings: Franciscan Health Center Building 01 is a 2 story building with a small partial basement. The 2nd level is all office space with no resident access The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(000) construction. In 1970 an addition was constructed that was determined to also be of Type II(00) construction. This building is fully fire sprinkler protected. The entire facility has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a licensed capacity of 44 beds and had a census of 42 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 fire separations was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observations revealed that there is a penetration located around a pipe that is passing through the 2 hour fire barrier above the ceiling tile over the double doors located by the beauty shop. This deficient condition was verified by a	K 011	K011 In order to comply with NPFA 101 FHC will provide fire retardant caulking on all areas that require a 2 hour fire wall resistance rating. The penetration located around a pipe that is passing through the 2 hour fire barrier in the ceiling (by the beauty shop) has been sealed with fire retardant caulking. Environmental Director has toured and inspected the building for any areas that have a 2 hour fire barrier to ensure penetrations are fire stopped. 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	5/6/16

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	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/29/2016**

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K 011	Continued From page 3 Maintenance Supervisor.	K 011		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect 42 of 42 residents, as well as an undetermined number of staff, and visitors by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observations revealed that the patio door located in the dinning room has a door to the outside that does not lead to a public way. This door is not part of the facility's required exits and is not labeled with a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This deficient condition was verified by a Maintenance Supervisor.	K 022	In order to comply with NFPA 101	2000 Edition, sections 7.10.1.7 and 7.10.8.1, FHC will provide signage to ensure that dining room door is properly labeled. A sign has been posted on the patio door with labeling that reads NO EXIT The lettering consists of 2 inches in height and a stroke width of 3/8 inch Environmental Service Director has inspected all other areas of the facility to ensure compliance with NFPA 7.10.1.7 and 7.10.8.1. Person responsible: Environmental Service Director Completion date: 5-06-2016	5/6/16

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K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 14 of 42 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observation revealed that there is a penetration found around the communication wires that are passing through the 1 hour smoke barrier above the ceiling tiles over the smoke barrier doors that are located by resident room 311. This deficient condition was verified by a Maintenance Supervisor.	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 311 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	5/6/16
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 052		5/6/16

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K 052	Continued From page 5 maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 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, 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). This deficient condition was verified by a Maintenance Supervisor.	K 052	In order to comply with NFPA 101 ‖ 2000 edition, sections 19.3.4 and 19.3.6.3.2 as well as NFPA 72 Section 7.1, the Environmental Service Director will perform monthly tests of the digital alarm communicator transmitter. The fire alarm drill reports and alarm maintenance testing documentation will be in place and available to the administrator to monitor for compliance. The Environmental Service Director will ensure that fire drills conducted during non-business hours will include tests of the digital alarm communicator. Person responsible: Environmental Service Director Completion date: 5-06-2016	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to	K 056		5/6/16

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K 056	Continued From page 6 the building fire alarm. 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. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 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. 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: 1. The current spare sprinkler head box located in the care center did not contain at least two spares of every type and style of sprinkler head located throughout the facility. 2. The sprinkler gauges located at the primary riser assembly have not been re-calibrated or replaced within the last 5 years. This deficient condition was verified by the Maintenance Supervisor.	K 056	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 has supplied 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 gauge valve. 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	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		5/6/16

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K 062 SS=C	Continued From page 7 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 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 19.7.6, 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 interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for 2 of 4 quarterly fire sprinkler flow test having been completed. This deficient condition was verified by a Maintenance Supervisor.	K 062	In order to comply with NFPA 101 ‖ 2000 edition, section 19.7.6 and 4.6.12 and NFPA 13, NFPA 25, section 9.7.5 FHC will ensure the Automatic Sprinkler System will be properly inspected and maintained. The facility sprinkler vendor conducted a flow test on 3-17-2016 The Environmental Service Director will conduct the other quarterly fire sprinkler flow tests, and maintain documentation that the testing was completed. Responsible person: Environmental Service Director Completion date: 5-06-16	
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are	K 104		5/6/16

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K 104	Continued From page 8 not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to 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 it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor, that the facility had failed to provide documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by the Maintenance Supervisor.	K 104	In order to comply with NFPA 101 2000 edition, section 8.3.5 and NFPA 90 (99) Section 5.1.2 and 5.2 FHC will ensure that Fire/Smoke Dampers are tested or inspected every 4 years. Facility does not have smoke dampers. HVAC System shuts down automatically upon activation of the fire alarm. Facility has approved supervised automatic sprinkler system in accordance with 19.3.5.3 Environmental Service Director will maintain the quarterly testing of the sprinkler system. Responsible person: Environmental Service Director Completion date: 5-06-16	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be	K 144		5/6/16

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K 144	Continued From page 9 in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4, 6-4.1, and 6-4.2.2. The deficient practice could affect 75 of 75 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observations revealed that the facility's letter of reliable service for their natural gas fuel supply did not provide the following criteria: 1. a statement of reasonable reliability of the natural gas delivery 2. a brief description 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 deficient condition was verified by the Maintenance Supervisor.	K 144	In order to comply with NFPA 101 - 2000 Edition, sections 9.1.3 and 1999 NFPA 110 6-4, 6-4,1 and 6-4.2.2, FHC will ensure that the facility has in place a letter that provides the following: A letter will be obtained from the City of Duluth Gas Department that includes: 1. Statement of reasonable reliability of the natural gas delivery 2. A brief description 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 facility to verify compliance with K1444 Responsible person: Environmental Service Director Completion date: 5-06-2016	

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	245258	A. BUILDING **02 - FRANCISCAN HEATLH CENTER** B. WING _____	**03/29/2016**

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K 000	INITIAL COMMENTS 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **02 - FRANCISCAN HEATLH CENTER** B. WING _____	**03/29/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 2 separate buildings: Franciscan Health Center Building 02 is a 2006 addition and is a one (1) story building with no basement. The construction type was determined to be of Type II(000). Building 02 is properly fire separated from building 01 by a 2 hour fire separation. This building is fully fire sprinkler protected. The entire facility has a complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a licensed capacity of 44 beds and had a census of 42 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 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, 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).	K 052	In order to comply with NFPA 101	2000 edition, sections 19.3.4 and 19.3.6.3.2 as well as NFPA 72 Section 7.1, the Environmental Service Director will perform monthly tests of the digital alarm communicator transmitter. The fire alarm drill reports and alarm maintenance testing documentation will be in place and available to the administrator to monitor for compliance. The Environmental Service Director will ensure that fire drills conducted during non-business hours will include tests of the digital alarm communicator. Person responsible: Environmental Service Director Completion date: 5-06-2016	5/6/16

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K 052	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 056 SS=D	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. 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: 1. The current spare sprinkler head box located in the care center did not contain at least two spares of every type and style of sprinkler head	K 056	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 gauge valve. 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	5/6/16

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K 056	Continued From page 4 located throughout the facility. 2. The sprinkler gauges located at the primary riser assembly have not been re-calibrated or replaced within the last 5 years. This deficient condition was verified by the Maintenance Supervisor.	K 056		
K 062 SS=C	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. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, a review of documentation and interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for 2 of 4 quarterly fire sprinkler flow test having been	K 062	In order to comply with NFPA 101 □ 2000 edition, section 19.7.6 and 4.6.12 and NFPA 13, NFPA 25, section 9.7.5 FHC will ensure the Automatic Sprinkler System will be properly inspected and maintained. The facility sprinkler vendor conducted a flow test on 3-17-2016 The Environmental Service Director will conduct the other quarterly fire sprinkler flow tests, and maintain documentation that the testing was completed. Responsible person: Environmental Service Director Completion date: 5-06-16	5/6/16

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K 062	Continued From page 5 completed. This deficient condition was verified by a Maintenance Supervisor.	K 062		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to 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, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor, that the facility had failed to provide documentation verifying that the fire and smoke dampers has been tested or inspected within the	K 104	In order to comply with NFPA 101 2000 edition, section 8.3.5 and NFPA 90 (99) Section 5.1.2 and 5.2 FHC will ensure that Fire/Smoke Dampers are tested or inspected every 4 years. The Facility HVAC Contractor has completed the fire and damper testing and inspection and will be scheduled to do the routine checks every 4 years as required. The Environmental Services Director will maintain documentation on the testing and inspecting of the Fire/Smoke Dampers to ensure compliance with K104. Responsible person: Environmental Service Director	5/6/16

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K 104	Continued From page 6 last 4 years. This deficient condition was verified by the Maintenance Supervisor.	K 104		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4, 6-4.1, and 6-4.2.2. The deficient practice could affect 75 of 75 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 11:30 AM to 3:30 PM on 03/29/2016, observations revealed that the facility's letter of reliable service for their natural gas fuel supply did not provide the following criteria: 1. a statement of reasonable reliability of the natural gas delivery 2. a brief description 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	K 144	In order to comply with NFPA 101 - 2000 Edition, sections 9.1.3 and1999 NFPA 110 6-4, 6-4,1 and 6-4.2.2, FHC will ensure that the facility has in place a letter that provides the following: A letter will be obtained from the City of Duluth Gas Department that includes: 1. Statement of reasonable reliability of the natural gas delivery 2. A brief description 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 facility to verify compliance with K1444 Responsible person: Environmental Service Director Completion date: 5-06-2016	5/6/16

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K 144	Continued From page 7 This deficient condition was verified by the Maintenance Supervisor.	K 144		