Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 2, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: January 6, 2023

Dear Administrator:

On January 20, 2023, we notified you a remedy was imposed. On February 23, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 6, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 20, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
January 20, 2023

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: January 6, 2023

Dear Administrator:

On January 6, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 6, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 6, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Franciscan Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 6, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/3/23 through 1/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		2/18/23

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

Electronically Signed | 01/27/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 Based on interview and document review, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 1/4/23, between 9:30 a.m. and 12:30 p.m. it was identified through document review the emergency generator maintenance and testing weekly generator inspections were not performed from 1/31/22 to 7/1/22. In addition, the annual generator inspections were not performed. The last available document state an annual inspection date of 3/11/21. The maintenance director and administrator verified these deficient findings at the time of discovery.	E 041	E: 041 It is Franciscan Health Center's policy to provide proper generator testing and inspections. ESD and/or designee will implement corrective action for this deficiency by: • Allied Generator inspected the generator and ran a load bank test on 01/17/2023. ESD and/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by deficient practice. ESD and/or designee will implement measures to ensure that this practice does not recur including: • Allied Generator inspected the generator and ran a load bank test on 01/17/2023. • The Environmental Service Director (ESD) was educated on ensuring generator testing and maintenance are done timely and that documentation is placed in Fire Book so it is available during LSC Survey. ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • The Administrator will monitor monthly to ensure future compliance. Completion Date: February 18, 2023	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 On 1/3/23 through 1/6/23, a standard recertification survey was conducted at your facility. Complaints were also investigated during the survey. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52587122C (MN89660), with a deficiency cited at F755. H5258067C (MN80979); however, no deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5258064C (MN80377) H5258065C (MN82064) H5258066C (MN82187) H52586301C (MN88840) H52587105C (MN89641) H52587065C (MN87756) H52587066C (MN89494) H52587067C (MN87948) H52587069C (MN87545) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 5	F 000		
F 584 SS=E	regulations has been attained. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the tub/shower rooms were kept clean and sanitary and free of clutter and personal items voiced by 1 of 1 residents (R17) with the potential to affect all 38 residents identified by the facility who utilized the shower/tub room and shower room. Findings include: R17's quarterly MDS dated 12/14/22, indicated R17 was cognitively intact with a diagnosis of a depressive disorder. During an interview on 1/3/23, at 1:17 p.m. R17 stated the shower rooms were dirty, and would often see old soap scum, debris, and hair on the floors. During an observation on 1/4/23, at 1:26 p.m. in the large shower/tub room the following was identified: - an unused plastic bag was hanging on a shower chair in the shower -a necklace was hanging on the call light by the shower opening -the mesh laundry bins had four areas with a white substance on them (approximately one inch in diameter, and two to three and one half inches in length) -a one gallon bottle of dial soap for hair and body with no cover observed on the top of the laundry bin and another bottle of the same on the floor also without a cover	F 584	F: 584 It is Franciscan Health Center's policy to provide a clean and sanitary shower/tub room. DON and ESD/or designee will implement corrective action for resident R17 affected by this practice by: • Shower room was deep cleaned by environmental services and resident's personal items were removed and brought to resident individual room. DON and ESD/or designee will assess residents having the potential to be affected by this practice including: • All residents have the potential to be affected by deficient practice. DON and ESD/or designees will implement measures to ensure that this practice does not recur including: • The Equipment and Environmental Cleaning and Disinfection policy was reviewed and updated as needed. • Nursing staff will be provided education on facility shower cleaning between each resident use and proper use of cleaning product. • Nursing staff will be educated to remove all resident personal items from shower room when resident shower complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 -a container of baby powder on the floor between the shower and the laundry bins -on the floor one tennis ball from a walker The top of the sink vanity was covered with the following items: -a gray stuffed elephant -two large plastic mugs with handles no covers, one with a drinking straw in the cup -lotion bottle -shampoo bottle with hair stuck on the pump opening -one hair dryer plugged into an electrical outlet -one hair dryer not plugged in -three bottles of hair conditioner -one plastic hanger -two packets of wipes -one box of gloves -one box of face tissues -a plastic bag -one bottle of Buckeye eco neutral disinfectant Tub: -hair noted on the seat During an interview on 1/4/23, at 1:38 p.m. nursing assistant (NA)-C stated the shower/tub rooms were supposed to be cleaned after each resident's use and deep cleaned by the housekeeping staff. She thought the white splashes on the laundry bags might have been soap. The soap bottles usually had covers on them. NA-C thought the tennis ball must have come off a resident's walker. NA-C could identify the plastic necklace and the keys and stated there was only one resident who used the tub. said it would have been his nigth to use the tub on 1/3/23, and it looked to her like the tub had not been cleaned since it was used the nigth before	F 584	• Environmental staff will be provided education on Equipment and Environmental Cleaning and Disinfection Program with the proper use of cleaning product. • Environmental Services weekly cleaning schedule developed for shower room. DON and ESD/or designees will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying shower being cleaned between resident with proper use of cleaning product will be performed 4X/week X 4 weeks, 2X/week X 2 weeks, and then monthly thereafter, until compliance is achieved, beginning the week of February 6th, 2023. • Environmental cleaning audits will be performed weekly beginning the week of February 6th 2023, until compliance is achieved. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 after she noted the hair in the tub. NA-C looked at the sink area and stated "that's not okay", and verified the sink vanity was covered in items. During an interview on 1/5/23, at 1:44 p.m. NA-D stated she it was her practice to clean the shower after each use by spraying the shower with the Buckeye eco neutral disinfectant, wiping it off, and then rinsing the shower with water. NA-D didn't know if the disinfectant needed to be left on for any specific time. NA-D picked up the bottle and read the directions "Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry". NA-D verified she was not allowing the disinfectant to remain on the surface for 10 minutes. During an observation on 1/4/23, at 1:45 p.m. in the small shower room: -water dripping in the shower -black comb on the floor -floor in the shower wet -shampoo bottle with hair stuck to it -gallon size bottle of dial soap no cover -hair brush on the sink -pink safety razor in a baggy on top of the towel dispenser -hair in the sink -hair brush on the bottom shelf of a wire rack between the sink and the toilet -cloth child's book on the middle shelf of the wire rack -three pairs of socks on the middle shelf of the wire rack -brown substance (about one inch by two inches) on the wall next to the toilet approximately nine inches from the floor	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 Cabinet: -bottom shelf of the closet lying on the floor no longer intact (shelf had disintegrated with rough, brown, jagged edges) -plastic bin on a shelf in the closet with brown/black residue in the bottom of the basket -inside of closet door with yellow substance approximately two inches by three inches -one bottle of Buckeye eco neutral disinfectant on the sink along with a plastic bag During an interview on 1/4/23, at 1:53 p.m. housekeeping aide (HA)-A stated the shower/tub rooms were cleaned toward the end of each day, his shift was 9 a.m. to 5:30 p.m.. During an interview on 1/4/22, at 1:55 p.m. registered nurse (RN)-A entered the shower room and turned off the dripping water, she verified the items noted above. RN-A opened the cupboard and verified the bottom of the cupboard floor had disintegrated and was no longer in place, said she thougth the yellow substance on the inside of the closet door was maybe shampoo or conditioner. RN-A verified the plastic basket had a brown/black residue in the bottom of the basket and removed the basket from the cupboard. RN-A looked at the wall by the toilet and stated, "that looks like poop" and said, "it could use some cleaning". RN-A stated the shower/tub rooms should be cleaned and disinfected after each use and all personal items should have been removed, in addition, she would expect to see covers on the soap bottles. During an interview on 1/6/23, at 11:45 a.m. the director of nursing stated it was his expectation the shower/tub rooms would be cleaned and sanitized after each use and all personal items	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10 removed. The manufacturer's package insert for Buckeye Eco Neutral disinfectant dated 6/20, directed staff to "Spray 6-8 inches from the surface, rub with a brush, cloth or sponge. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry". The undated facility policy Housekeeping Aides General Cleaning Policy did not address cleaning shower/tub rooms.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure ordered interventions for low blood sugars were followed for 1 of 1 resident (R35) reviewed for diabetic care. Findings include: R35's annual Minimum Data Set (MDS) dated 10/26/22, indicated R35 had a diagnosis of diabetes mellitus. R35's physician order dated 6/7/22, included for a	F 684	F: 684 It is Franciscan Health Center's policy to provide residents with proper interventions in regards to low blood sugars DON and/or designee will implement corrective action for resident R35 affected by this practice by: • R 35 was assessed by RN on 1/6/2023 and noted to be at her baseline. • R35's Physician Orders and Care Plan were reviewed and updated as	2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 hypoglycemic episode , with a blood sugar less than 100, as needed give a glucose tab and recheck in 15 minutes until the blood sugar was greater than 150. There are orders for glucagon 1 milligram if unable to give oral. R35's undated All Vitals flow sheet indicated the following blood sugars: - 12/14/22, 4:38 p.m. blood sugar 60 no 15 minute blood sugar re-check documented. - 12/18/22, 4:17 p.m. blood sugar 78 no 15 minute blood sugar re-check documented - 12/31/22, 5:20 a.m. blood sugar 89 no 15 minute blood sugar re-check documented. - 1/5/23, 2:43 a.m. blood sugar 77 no 15 minute blood sugar re-check documented. - 1/5/23, 5:30 p.m. blood sugar 89 no 15 minute blood sugar re-check documented. R35's progress notes from 12/14/22, through 1/5/23, failed to identify what interventions were completed for the blood sugars less than 100. On 1/6/23, at 11:15 a.m. registered nurse (RN)-D reviewed R35's blood sugars and progress notes and stated she would have expected to see a blood sugar re-check and a progress note per the physician order. During an interview on 1/6/23, at 11:57 a.m. the director of nursing stated he would expect nursing staff to follow the physician order in regard to blood sugars less than 100. The facility policy Insulin Information, dated 7/13, did not address follow up for low blood sugars.	F 684	necessary to reflect appropriate blood sugar interventions. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents who have blood sugar monitoring have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • On 1/24/2023 nursing staff audited all residents who are having their blood glucose levels monitored and reviewed their individual orders to verify that provider's orders were clear and orders were being followed by nursing staff • Education provided to all licensed nursing staff and TMA's on following all provider orders as prescribed and following specific orders written for R35. Education provided for house standing orders and diabetic monitoring/treatment. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits will be conducted to ensure that providers blood sugar monitoring orders are followed per physician orders 3X/week X 4 weeks, 2X/week X 2 weeks, and then monthly thereafter, until compliance is achieved, beginning the week of February 6th, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12	F 684	Completion Date: February 18, 2023	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ordered and assessed interventions to prevent the development and/or worsening of pressure ulcers for 1 of 2 residents (R29) reviewed for pressure ulcers. Findings include: The Long-Term Care Facility Resident Assessment Intrument (RAI) 3.0 User's Manual dated 10/19, defined pressure ulcers as "A pressure ulcer/injury islocalized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present	F 686	F: 686 It is Franciscan Health Center's policy to provide ordered and assessed interventions for residents with pressure ulcers DON and/or designee will implement corrective action for resident R29 affected by this practice by: • R29's Care Plan and Physician Orders were reviewed and updated as necessary to reflect appropriate interventions in regards to his pressure ulcers • R 29 wounds were assessed by RN on 01/5/2023 and noted wounds to be at baseline. R 29 heals floated and Mepilex applies to heal (2) as ordered. CNP from	2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13 as intact skin or an open ulcer and may be painfu. The RAI defined the following pressure ulcer stages as follows: - Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister. - Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling - Deep Tissue Injury (DTI) is a Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. R29's quarterly Minimum Data Set (MDS) dated 11/2/22, identified R29 had severe cognitive impairment. R29 had total dependence for all activities of daily living (ADL) and was totally incontinent of bowel and bladder. Diagnoses included anemia and dementia. R29 had a Stage 2 pressure ulcer. R29's undated care plan identified R29 equired extensive assistance for all activities of daily living. R29's was at risk for skin breakdown related to impaired mobility with interventions that included inspect skin weekly, float heels while in bed, and turn/reposition every two hours. R29's integrated wound care note(s) identified the	F 686	integrated wound services has noted over the following weeks that wounds continue to improve with prescribed interventions. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents with pressure ulcers have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • All residents with specific wound interventions assessed/audited by nursing on 01/25/2023 to verify that interventions are being followed. • IDT reviewed all residents with wounds to monitoring provider orders for accuracy. • All residents with specific wound interventions were updated and listed on nursing/NAR care streams. • Education of Skin pressure prevention and breakdown provided to all nursing staff. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits will be conducted to ensure that interventions are in place per resident plan of care 3X/week X 4 weeks, 2X/week X 2 weeks, and then monthly thereafter, until compliance is achieved, beginning the week of February 6th, 2023. • Audit results will be brought to the QAPI committee quarterly for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14 following: - 11/8/22, there was a new consultation for Stage 2 pressure ulcers (PU) to R29's coccyx. Measurements were 4.5 centimeters (cm) long (L) x 2 cm wide (W) x 0.1 cm deep (D). Orders directed to clean with wound cleaner and cover with Mepilex, and the dressing would be changed every three days. - 11/29/22, there was a consultation for the Stage 2 PU to R29's coccyx and a new DTI to both of R29's heels. Both heels measured 2cm L x 3 cm W x 0 cm D. Orders were identified as apply Mepilex every three days, and as needed, along with the heels needed to be floated. - 12/27/22, indicated a subsequent visit for PU to coccyx and bilateral heel ulcers. The PU to the coccyx had increased in stage from a Stage 2 to a Stage 3. Orders were changed to clean PU with wound cleaner, apply Collagen to wound and apply Mepilex every three days; and to reposition per facility protocol. - 1/3/23, indicated the right heel had changed from a DTI to a Stage 2 pressure ulcer (per the facility record). R29's physician orders dated 11/30/22, directed bilateral heel treatment every three days during day shift and included apply skin prep to wound and cover with Mepilex-dressing that is covered with an elastic bandage on all sides and is left on for three days, and to float heels. Orders dated 12/28/22, included coccyx pressure ulcer treatment for every three days on day shift clean PU with wound cleaner, apply Collagen to wound bed and wound would be covered with Mepilex.	F 686	further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15 During continuous observation on 1/5/23, at 7:16 a.m. to 10:07 a.m. R29 was laying flat on his back with his head elevated to a 25-degree angle. R29's lower right leg was laying on a pillow, the heel was pressing against the mattress and placed an indentation into mattress. The left leg was lying next to a pillow and the heel was directly pressing against the mattress the same as the right heel. On 1/5/23, at 9:52 a.m. registered nurse (RN)-C entered the room, gave R29 medication and then walked out of room. She did not elevate the heels or reposition R29 before leaving. On 1/5/23, at 9:57 a.m. RN-C reentered room and lifted both of R29's legs. The right heel was observed to have dark bruising over the bottom of the heel and had redness that surrounded the bruising. The skin was dry, cracked and peeling. RN-C described the heel as hard when touched. RN-C's measurements of the right heel were 3 cm L x 4cm W. The left heel also had dark bruising in the center of the bottom of the heel with redness around the bruising. The measurements for the left heel were 2cm L x 3cm W. During interview on 1/5/23, at 9:55 a.m. RN-C stated R29 had a Stage 3 PU on his coccyx, a Stage two PU to his right heel and a DTI to his left heel. The coccyx did have orders for a dressing change and the heels had an order to wipe with barrier wipes. R29 was to be repositioned every two hours and the heels should be floating above the mattress to prevent pressure on heels. RN-C entered back into room and confirmed R29's heels were laying on	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 16 mattress and creating pressure. RN-C elevated both legs and there was no Mepilex observed on either heels or in the bed. RN-C stated she was not aware of the order for Mepilex but did review chart and R29 should have had mepilex on both heels. RN-C was not sure why R29 did not have Mepilex on his heels, but he should have. During interview on 1/5/23, at 10:37 a.m. nurse assistant (NA)-A stated there were assigned to R29's hallway since the start of shift at 7:00 a.m. NA-A was not aware he was responsible for R29 until another unidentified staff member mentioned it shortly before the interview. NA-A was not sure when R29 was repositioned but knew it needed to be every two hours. During interview on 1/6/23, at 10:42 RN-D stated any resident with a PU on the coccyx and/or heels should be repositioned every two-hours and have the heels floated. R29 had a PU to the coccyx and heels. There were orders for the heels to be floated and for staff to reposition per facility protocol, which RN-D stated would be every two-hour repositioning. There were also orders for Mepilex to heels. RN-D was not sure why the Mepilex was not on the heels, as they should have been. During interview on 1/6/23, at 1:11 p.m. the director of nursing (DON) stated staff were expected to follow orders as they are written to protect the resident skin and for comfort. The undated facility policy Repositioning Policy identified all residents would be repositioned per their individualized assessments.	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 17 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were available to be administered as prescribed by the physician for 3 of 6 residents (R37, R17,	F 755	F: 755 It is Franciscan Health Center□s policy to ensure medications are available to be administered as prescribed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 18 R41) reviewed for pharmacy services. Findings include: R37's quarterly Minimum Data Set (MDS) dated 9/28/22, indicated R37 had diagnoses which included amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function) and chronic pain. R37's undated Order Summary, identified R35 had orders for Miralax (laxative used for constipation) 17 grams (gm) by mouth twice daily. R37's electronic medical record (EMAR) dated 1/5/23, indicated R37 did not receive Miralax on 1/5/23, the reason indicated was "drug not available". During an observation on 1/5/23, at 11:12 a.m. R37 did not have miralax available for administration. During an interview on 1/6/23, at 9:24 a.m. trained medication aide (TMA)-B stated R37's Miralax was not available for administration on 1/5/23. R17 was missing her calcium and vitamin D as well on the same day. If medications were missing the cart staff would need to check the cart again, check the medication room, look through the faxed re-order papers to see if someone had previously re-ordered the medication. The process for re-ordering medication "doesn't work". There were too many faxed papers to look through, may find multiple requests, never sure if the medication arrived or if it was not available because they were waiting for insurance to approve, there was nothing in the process to indicate if the medication was	F 755	DON and/or designee will implement corrective action for resident R17, R37, and R41 affected by this practice by: " On 01/5/2023 all medications for R 17, R37, and R41 ordered from pharmacy and given upon medication arrival. All providers notified of missed medications. DON and/or designee will assess residents having the potential to be affected by this practice including: " All residents have the potential to be affected by this deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: " Audit performed on 01/26/2023 by nursing to assure that all medications ordered are at facility to be administered as ordered. " IDT reviewed the Medication ordering/receiving policy and procedure processes. Process changes initiated as needed. " Facility assigned individual nurse to review medications carts weekly to ensure that all medications available for preceding week. If unavailable the nurse will order medications from the pharmacy or work with the provider to obtain orders or scrips as needed to ensure that medications available for administration as ordered by the provider. " Pharmacy to provide tool to assist nurse with tracking medications and the reordering medications to ensure that medication ordered timely and available to nursing when ordered by the provider.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 19 re-ordered. R17's quarterly MDS dated 12/14/22, included diagnoses of fibromyalgia (widespread muscle pain and tenderness), type two diabetes mellitus, osteoarthritis (degenerative joint disease), and depressive disorder. R17's undated Order Summary identified R17 had the following orders: - Calcium Citrate with Vitamin D3 (used to treat conditions caused by low calcium levels) 315-250 milligrams (mg) one tablet by mouth twice a day. - Vitamin D (helps the body absorb and retain calcium and phosphorus both are critical for building bone) 50 micrograms (mcg) one tablet by mouth per day in the morning. R17's electronic medical record (EMAR) dated 1/5/23, identified R17 did not receive calcium citrate with vitamin D3 or vitamin D on 1/5/23. R17's EMAR indicated the drugs were not available and not given. During an interview on 1/3/23, at 1:03 p.m. R17 stated she was frequently missing medications. R17 started counting her medications to see if they were all there. R17 stated the staff would not tell her if a medication was missing or not available. R41's admission MDS dated 11/7/22, included diagnoses of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), diabetes mellitus, atherosclerotic heart disease (build up of fats, cholesterol and other substances in and on the artery walls), cerebrovasuclar disease (stroke), and dementia.	F 755	" Education provided to licensed nursing staff and TMA staff on process for ordering medications from pharmacy. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: " Random medication audits will be completed to assure medications are available for administration as prescribed, by DON/designee 4X/week X 4 weeks, 2X/week X 2 weeks, and then monthly thereafter, until compliance is achieved, beginning the week of February 6th, 2023. " Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 20 R41's undated Order Summary identified R41 had orders for magnesium (supports muscle and nerve function and energy production) 200 mg one tablet by mouth per day in the morning. R41's EMAR dated 1/5/23, identified R41 did not receive her morning dose of magnesium on 1/5/23, no reason was documented. During an interview on 1/6/23, at 8:54 a.m. registered nurse (RN)-E stated on 1/5/23, R41's magnesium was not available for administration. During an interview on 1/6/23, at 11:24 a.m. RN-A stated some medications were on an automatic re-order schedule, some medication like narcotics needed to be re-ordered when they were getting low (seven or less left). Insulin pens should be re-ordered when the last pen was removed from the medication refrigerator. RN-A stated this did not always occur. During an interview on 1/6/23, at 11:47 a.m. the director of nursing stated staff should contact the pharmacy when a medication was getting low. The pharmacy could be contacted by phone or by faxing a request for the medication. If a medication was not available during a medication pass, the staff should explore the reason and should contact the provider as well that it was not given. Thrifty White Skilled Nursing Policy and Procedure dated 3/22, outlined the re-ordering procedure as listed below: "Refill Medication Orders. a) Requests for refills of current medications are	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 21 either written on a medication reorder form or the reorder sticker is placed on the reorder form provided by the pharmacy for that purpose. b) Reorder medications three to five days in advance of need to assure an adequate supply is on hand. When reordering medications that require special processing (such as Schedule II controlled substances), order at least seven days in advance of need. c) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. d) The refill order is faxed or otherwise transmitted to the pharmacy."	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 22 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 insulin pens, were appropriately labeled according to manufacturer's guidelines for 3 of 6 residents (R35, R24, R17) identified to not have ordered medications available for administration. Findings include: During a medication administration observation on 1/4/23, at 11:14 a.m. for R35. The Humalog insulin pen had a yellow sticker for an open date and an expiration date. The information was not filled in. Registered nurse (RN)-E verified the information should have been filled out when the pen was first opened, she thought the insulin pen was good for 28 days after opening but could not verify when the pen was opened. During a medication administration observation on 1/4/23, at 11:21 a.m. for R24. The Humalog insulin pen had a yellow sticker for an open date and expiration date. The information was not filled in. RN-E verified the information was missing and should have been filled out when the pen was first opened. During observation of the Bayside medication cart on 1/4/23, at 11:33 a.m. with trained medication aide (TMA)-A identified the stock Mucinex R17 used was expired on 10/22.	F 761	F: 761 It is Franciscan Health Center's policy to ensure medications are labeled properly. DON and/or designee will implement corrective action for residents R17, R24, and R35 affected by this practice by: • Expired medications or medications lacking proper labeling were removed from R17, R24, and R35's and replaced on 01/04/2023. DON and/or designee will assess residents having the potential to be affected by this practice including: • All residents have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • Nursing staff audited both medication carts on 1/23/2023 for any unlabeled or opened/ expired medications. No other mislabeled medications found. • IDT reviewed the Medication Storage Policy processes related to medication storage and proper labeling of open and expired dates. Process changes initiated as needed. • Education provided to all licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 23 During an interview on 1/4/23, 11:56 a.m. TMA-A stated she did not know how the carts were checked for outdated medications and verified the Mucinex was expired. On 1/4/23, at 2:15 p.m. RN-A stated medications should be checked for expiration dates weekly on the night shift. They should check the medication carts, the treatment cart, and the medication room. During an interview on 1/6/23, at 11:47 a.m., the director of nursing (DON) stated insulin pens should be dated when opened and an expiration date should be filled in on the yellow sticker and medications should not be used past the manufacturer's expiration date. The facility Medication Storage policy dated 7/21/16, directed staff to ensure drug containers did not have incompleted labels. In addition, staff were directed to not use outdated drugs or biologicals. Thrifty White Skilled Nursing Policy and Procedure Manual dated 3/2022, directed staff to check the "date open" to assure that the medication is not expired or in use past the manufacturer's guidelines.	F 761	nursing and TMA staff regarding proper labeling of medications while stored. DON and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying appropriately labeled and dated medications will be performed by DON/designee 4X/week X 4 weeks, 2X/week X 2 weeks, and then monthly thereafter, until compliance is achieved, beginning the week of February 6th, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure perishable food was stored at a safe temperature to prevent bacteria growth and/or food toxin production that can lead to food borne illness. This deficient practice had the potential to affect all 43 residents that consumed food from the milk cooler fridge. Findings include: On1/3/23 at 12:08 p.m. the milk cooler containing fruit, dairy productes and vegetables had a temerpature reading of 52 degrees fahrenheit (F). The dietary manager (DM) confirmed the temperature and stated they had just stocked the fridge. On 1/4/23 at 2:43 p.m. cook (C)-B removed the thermometer from the milk cooler. The temperature of the milk cooler was 46 degrees F. C-B stated a tray of salads was put in the fridge recently.	F 812	F: 812 It is Franciscan Health Center's policy to store food in accordance with professional standards of food service safety. Dietary Manager and/or designee will implement corrective action for resident affected by this practice by: • No individual residents were specifically cited. Dietary Manager and/or designee will assess residents having the potential to be affected by this practice including: • All residents have potential to be affected by deficient practice. Dietary Manager and/or designee will implement measures to ensure that this practice does not recur including: • All soup bases, string cheese, yogurt and milk were discarded on 01/05/2023. • Gartner Refrigeration was called and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 On 1/5/23 at 7:25 a.m. C-A checked the thermometer that was at the bottom of the milk cooler and the temperature was at 42 degrees F. On 1/5/23, at 11:34 a.m. the dietary manager (DM) removed the thermometer from the milk cooler and stated the temperature was 46 degrees F. The DM took the internal temperature of some of the dairy items. and identfied the followin tepuratures: single serve yogurt 43.3 degrees F and single serve milk 44.1 degrees F. DM explained the high core temperatures were from everyone being in and out of cooler." I don't like it one bit, that the stuff is higher than supposed to be." DM would make sure nobody went in the milk cooler so it could be rechecked in an hour. At this time, DM indicated no other action would be taken related to the milk and yogurt that was out of temp, the solution provided was to recheck in an hour to make sure that the milk fridge was cold enough, at or below 40 degrees F. On 1/5/23 at 1:14 p.m. the DM retook the temperature of the milk cooler it was 44 degrees F. The following the internal temperatures were also taken and confirmed by the DM: Activia yogurt was 46 degrees F, Land O'Lakes yogurt was 50 degrees F and a glass of milk from a gallon jug from the milk cooler was 46.6 degrees F. DM stated she would call the refrigeration service to come and service the milk cooler. DM confirmed residents were getting food out of cooler since the first high temperature reading of 46 degrees F on 1/3/22. DM stated they would have to switch everything to different fridge, and the refrigeration service provider will likely require everything be moved. DM was not able to identify if the food was safe for consumption and	F 812	the cooler was serviced on 01/05/2023. • Cooler was thoroughly cleaned and restocked on 01/06/2023. • Dietary staff was educated on proper temperature ranges and the process to follow if temperatures are outside of appropriate range. • Dietary staff are currently monitoring temperatures of cooler twice daily. Dietary Manager and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits of food storage and fridge temps, will be completed by Dietary Manager/designee 5x/week until compliance is achieved beginning the week of February 6th, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26 responded, "I don't think anything is spoiled but that may be the wrong answer, I am going to call my corporate dietician. I'm not worried about soup bullion, and shredded cheese, but I am concerned about the milk and yogurt." On 1/6/23, at 8:47 a.m. the DM stated the milk cooler was serviced, fixed, and clean, and plugged in getting down to temperature. The corporate dietician called and said the DM did everything right. The DM stated she kept the shredded cheese that was not open because it had a white preservative on it, but all the Soup bases, string cheese, and yogurt that was left all got tossed. During telephone interview on 1/6/23, at 1:31 p.m. the dietician stated the service she provided for the facility was clinical, and she was not current on food service management, but the temperatures did seem high. The dietician suggested that the corporate dietician may know more about food storage and temperatures. On 1/6/23, at 1:57 p.m. the DM stated that all residents in the building eat from the kitchen. On 1/6/23, at 3:39 the administrator stated the milk cooler temperature was within limit prior to the survey. "I would expect if temperatures were running off more than a day, then action should be taken right away. " When made aware of temperatures yesterday, he advised the DM to throw all the food in the milk cooler away because the facility did not want to take any risks with their residents. The administrator stated the service provider on 1/5/23, found a Compressor coil that was over heating, and was not fixed.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 27 The facility policy Perishable Food Management dated 8/29/22, identified all perishable food would be appropriately managed to prevent bacteria from multiplying or forming food toxins to protect individuals from food-borne illness. The FDA considered "high risk" food to be soft cheeses, sea food, custard-filled bakery products, some fruits and vegetables, and baby formula. All coolers and refrigerators would be maintained at a food temperature at or below 40 degrees and dietary employees must report to their supervisor knowledge of any contaminated food and restrict use. Under references, the policy had a link to Refrigerator & Freezer Storage Chart dated 3/18, by the Food and Drug Administration (FDA). The reference identified 40 degrees F as the temperature to keep food from spoiling and becoming dangerous. The FDA Food Code dated 2022, identified "Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature "danger zone" of 5 degrees Celsius to 57 degrees celcius (41 degrees F to 135 degrees F) too long. Up to a point, the rate of growth increases with an increase in temperature within this zone.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure lift equipment was properly sanitized between resident use to prevent the spread of infection for 2 of 2 residents (R13 and R23) identified by staff who used a lift without sanitizing. In addition, the facility failed to ensure wipes utilized for lift equipment sanitization were not expired. This had the potential to impact 27 of 43 residents who required lift equipment for transfers. Findings included: During observation on 1/5/23, at 8:20 a.m. the Onyx Premiere sanitizing wipes container on the full total lift parked in the 300's hallway was empty with an expiration date of 5/22, which. The Onyx Premiere wipes container on the standing lift in the 300's hallway had an expiration date of 5/22. A standing lift was removed from a resident room	F 880	F: 880 It is Franciscan Health Center□s policy to use proper sanitation on mechanical lifts between each residents use. DON and ESD/or designee will implement corrective action for resident R13 and R23 affected by this practice by: " Staff caring for R13 and R23 will use proper sanitation on mechanical lifts. DON and ESD/or designee will assess residents having the potential to be affected by this practice including: " All residents transferred with a mechanical lift have potential to be affected by deficient practice. DON and ESD/or designee will implement measures to ensure that this practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 in the 300's hallway and was not sanitized before unknown staff left lift in hallway. On 1/6/23, upon entrance to the building around 7:00 a.m. unknown staff removed a full total lift from a unknown resident room in the Atrium area. The full total lift was not sanitized before unknown staff left the full total lift in the hallway. On 1/6/23, at 8:40 a.m. the Onyx Premiere wipes container on the full total lift in the 100's-atrium area had an expiration date of 5/22. At 8:41 a.m. the Onyx Premiere wipes container on the full total lift in the 300's hallway had an expiration date of 5/22. At 8:43 a.m. the full total lift parked in the 300's hallway had an empty Onyx Premiere wipes container with expiration date of 5/22. On 1/6/23, at 10:06 a.m. nursing assistant (NA)-A came out of R23's room with the full total lift containing an empty wipes container. NA-A walked away from full total lift without sanitizing it and left it in the hallway for use. On 1/6/23, at 10:09 a.m. a unknown staff member grabbed the full total lift with the empty wipes container and brought it to the other end of the hallway. On 1/6/23, at 10:20 a.m. NA-A stated that the full total lifts must be sanitized and usually did it on their down time. When I leave a room, I clean the full total lift so it doesn't cause cross contamination. When standing by the full total lift used to transfer R23 NA-A verified the full total lift Onyx Premiere wipes container was empty. The full total lift still needed to be sanitized from when R23 was transferred. The wipes container was empty when the full total lift was used for R13	F 880	does not recur including: " DPOC □ Root cause analysis was completed to identify the problem that resulted in the deficiency and a corrective action plan has been developed to prevent recurrence. " All DME lifts were disinfected throughout by environmental services within the facility " Environmental services did a facility wide audit for any other wipe containers that were past there expiration date. All found were discarded. " IDT reviewed the Disinfection and Resident Care Equipment and Environmental Cleaning and Disinfection Program Policies and processes. Process changes initiated as needed. " Education will be provided to all Nursing staff. " Nursing staff will be provided education on facility policy for cleaning DME and provide competency for the cleaning of DME between each resident use. " Knowledge as to where cleaning product is located and instructions for its use. " Reviewing product expiration date and to not use if past its expiration date. " Education will be provided to all Environmental staff " Environmental staff will be provided education on facility policy for cleaning DME. " Knowledge as to where cleaning product is located and instructions for its use. " Reviewing product expiration date	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 earlier today. NA-A didn't know where the Onyx Premiere wipes were stored. The full total lift was sanitized in the room using baby wipes and a washcloth with soap. Other staff would know that the full lift needed to be sanitized because it would be communicated to them if the lift did or did not need to be sanitized. On 1/6/23 at 10:28 a.m. registered nurse (RN)-B stated it is standard process for standing and full total patient lifts is to get sanitized right after they are done being used, this way staff know that if a lift is parked in the hallway, it is sanitized and ready to be used. On 1/6/23, at 12:08 p.m. registered nurse (RN)-A, who was also the infection preventionist (IP) stated the expired wipes currently in use were probably not doing what they should. It is an expectation staff would sanitize equipment between residents with designated sanitizing wipes to ensure proper equipment sanitization. The facility does frequent impromptu infection control education with staff. On the day the survey started, she met with all her aids and told them they needed to make sure they were sanitizing equipment between residents, and to make sure that all lifts had wipe containers. On 1/6/23, at 1:33 p.m. environmental services director (ESD) stated their supply vendor gave the facility expired Onyx Premiere wipes. At that time, the vendor told the ESD the Onyx Premiere wipes were fine, the wipes could still work, but they might dry up, and if they were dry then they should not use them. The ESD stated he was not sure if the Onyx Premiere wipes were still safe to use and would ask the director of nursing (DON) and RN-A what should be done.	F 880	and to not use if past its expiration date. " Weekly cleaning schedule developed for all DME DON and ESD/or designee will monitor corrective actions to ensure the effectiveness of these actions including: " Routine audits identifying disinfection of DME between resident uses will be completed by DON/designee 4X/week X 4 weeks, 2X/week X 2 weeks, and then monthly, these audits will continue until we achieve 100% compliance. Audits will begin the week of February 6th 2023. " Weekly environmental cleaning of all DME list equipment. " Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 On 1/6/23, at 3:27 p.m. the DON stated staff needed to properly sanitize equipment between residents with appropriate wipes for infection prevention. The DON could not say for sure if the wipes being used could safely be used for equipment sanitizing once past expiration date. On 1/6/23, at 3:39 p.m. the administrator stated as soon as it was known expired wipes were being used in the facility to sanitize, a directive was given to remove all expired wipes from use. The ESD was sent to buy new sanitizing wipes. The staff need to use sanitizing wipes within use dates, so we never have to question if they are effectively sanitizing and the equipment must be sanitized between residents with appropriate sanitizing wipes. On 1/11/23 at 1:00 p.m. the DON sent a e-mail that identifed 17 residents required use us full total lifts and 11 residents require standing lifts for transfers. Attempts to obtain information from the distributer and/or manufacturer to determine the efficacy of Onyx Premiere wipes used past expiration date was unsuccessful. The facility policy Cleaning/Disinfecting Resident Care Equipment dated 1/22/22, identified manufacturers instructions will be followed for proper use of cleaning/disinfecting (or detergent) products including recommended use-dilution; material compatibility; storage; shelf-life; and safe use and disposal." Line-item Mechanical lifts identified : "after each use, the areas coming into contact with the resident during cares/use will be disinfected, (e.g., handles, arms, knee pads,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 footrests) (housekeeping will clean full mechanical lift on a routine basis)."	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 43 residents who resided at the facility. Findings include: During an interview on 1/6/22, at 8:41 a.m. registered nurse (RN)-A stated she was working in the IP role but had no specialized training in infection control. RN-A asked the last	F 882	F: 882 It is Franciscan Health Center's policy to have a qualified Infection Preventionist. DON and/or designee will implement corrective action for resident R26 affected by this practice by: • No individual residents were specifically cited. DON and/or designee will assess residents having the potential to be affected by this practice including:	2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 34 administrator about getting training but never heard anything back from them. During an interview on 1/6/22, at 1:11 p.m. the director of nursing (DON) stated RN-A was designated as the infection control and preventionist for the facility. RN-A had not received any specialized training in infection control and prevention. The DON was not aware that the IP needed to have any specialized training before assuming the role. A facility policy Infection Prevention and Control Program indicated the infection prevention and control officer (IPCO) is responsible for care centers infection control and prevention program. The policy lacked information about the IPCO needed specialized training for this role.	F 882	• All residents have potential to be affected by deficient practice. DON and/or designee will implement measures to ensure that this practice does not recur including: • 1/6/2023 Administrator provided the link to CDC for Nurse A to perform/complete the CDC Infection Prevention Training modules as required. • IDT reviewed if any other requirements for the Infection Preventionist. No other requirements noted at this time. • Education provided to Infection Preventionist for completion of CDC course prior to2/18/2023. ESD and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Audits will be performed by the DON or designee to verify completion of CDC education by Infection Preventionist. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: February 18, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/04/2023. At the time of this survey, Franciscan Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/27/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as 1 building: 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. In 2006 a one-story addition without a basement was constructed that was determined	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 to be of Type II(000). 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 capacity of 47 beds and had a census of 43 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. Theis deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/04/2023 between 9:30am and 12:30pm, it was revealed by observation that the door to the basement storage room, larger than 50sqft and containing flammable materials did not have a door self-closing device. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 321	K321 FHC will have doors with self-closing devices In order to comply with NFPA 101 (2012 edition), Life Safety Code sections 19.3.2.1.3 and 19.3.2.1.5: 1. The basement storage room door will have a self-closing device installed by 02/18/2023. 2. The Environmental Service Director (ESD) completed a tour of facility and checked all other storage rooms for self-closing devices. The ESD was educated on ensuring all storage room doors have self-closing devices on them. 3. ESD will tour facility randomly to ensure future compliance. 4. The Environmental Service Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 01/04/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to perform the quarterly sprinkler system testing.	K 353	K353 FHC will have its sprinkler system maintained In order to comply with NFPA 101 (2012 edition), Life Safety Code section 9.7.5 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2: 1. Viking Sprinkler Company came in on 01/10/2023 and performed the annual sprinkler system test. ESD will perform quarterly checks for the next 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 2. On 01/04/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to provide documentation that an annual sprinkler system test was preformed. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 353	2. Viking Sprinkler Company came in on 01/10/2023 and performed the annual sprinkler system test. The ESD was educated on ensuring quarterly and annual testing be done timely. 3. The Administrator will monitor timeliness of quarterly and annual sprinkler testing. 4. The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespead impact on the residents within the facility.	K 355	K355 FHC will have properly maintained portable fire extinguishers In order to comply with NFPA 101 (2012 edition), Life Safety Code section 9.7.4.1 and NFPA 10 (2010 edition) Standard for	2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 6 Findings include: On 01/04/2023, between 9:30am and 12:30pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 355	Portable Fire Extinguishers section 7.3.1.1.1: 1. Annual fire extinguisher inspection was completed on 03/29/2022. Proper documentation was received/found on 01/04/2023 2. The ESD was educated on ensuring we receive proper documentation of fire extinguisher testing. 3. The Administrator will monitor to ensure future compliance. 4. The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 901	K901	2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 7 and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/04/2023, between 9:30am and 12:30pm, it was revealed during documentation review and an interview with the Environmental Services that the utility risk assessment document could not be provided at the time of the survey An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 901	FHC will have a completed Facility Risk Assessment In order to comply with NFPA 99 (2012 edition), Health Care Facilities Code section 4.1: 1. The Utility Risk Assessment was updated on 01/24/2023. 2. A copy of the risk assessment was placed in the Environmental Service Fire Book, for access during the Life Safety Code survey. The Environmental Service Director (ESD) was educated on ensuring the risk assessment is updated annually and available during survey. 3. The Administrator will monitor to ensure future compliance. 4. The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 8 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/04/2023, between 9:30am and 12:30pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 914	K914 FHC will have receptacle testing per regulation In order to comply with NFPA 99 (2012 edition), Standards for Health Care Facilities, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2: 1. Receptacle inspection will be completed by 02/18/2023. 2. The Environmental Service Director (ESD) was educated on the importance of completing receptacle inspection and having documentation readily available. 3. The Administrator will monitor to ensure future compliance. 4. The Environmental Service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 9	K 914	Director/Administrator are responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		2/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 10 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 01/04/2023, between 0930am and 1230pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 01/31/2022 to 07/01/2022. 2) On 01/04/2023, between 0930am and 1230pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing the annual generator inspections were not performed. The last available document state an annual inspection date of 03/11/2021. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 918	K918 FHC will have doors with self-closing devices In order to comply with NFPA 99 (2012 edition), Health Care Facility Code section 6.4.4.1.1.4 and NFPA 110 (2010 edition) Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2: 1. Allied Generator inspected the generator and ran a load bank test on 01/17/2023. 2. The Environmental Service Director (ESD) was educated on ensuring generator testing and maintenance are done timely and that documentation is placed in Fire Book so it is available during LSC survey. 3. The Administrator will monitor to ensure future compliance. 4. The Environmental Service Director/Administrator are responsible for correction and monitoring to prevent reoccurrence of the deficiency. 5. Completion Date: 02/18/2023	