

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email January 29, 2021

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: December 29, 2020

Dear Administrator:

On January 29, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 18, 2020

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: December 9, 2020

Dear Administrator:

On December 9, 2020, a survey was completed at your facility by the Minnesota Department of Health , to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Franciscan Health Center December 18, 2020 Page 2

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Franciscan Health Center December 18, 2020 Page 3

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

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

If substantial compliance with the regulations is not verified by March 9, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 9, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

Franciscan Health Center December 18, 2020 Page 4

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C 2/09/2020	
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F 000	INITIAL COMMENT	rs	F 0	00			
	survey was comple Minnesota Departm facility was found no requirements of 42 Requirements for L	th 12/9/20, an abbreviated ted at your facility by the nent of Health (MDH). The ot to be in compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.					
	The facility's plan or as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 ic submission of the POC will					
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with ocedures/Pharmacist/Records b)(1)-(3)	F 7:	55		1/22/21	
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services ovide routine and emergency als to its residents, or obtain ement described in cility may permit unlicensed ister drugs if State law ander the general supervision of					
		ures. A facility must provide vices (including procedures					

Electronically Signed 12/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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	R1's signed Physic included orders for (medication to treat potassium in the b	cian Orders dated 11/19/20, r potassium chloride-K-Dur at or prevent low amounts of lood) 20 meq (milliequivalent) daily at 5:00 a.m., 10:00 a.m.,		Medication cart audits compall medication administration administration administration administered accurately. All errors have identified and form of R1, R2, R3 and R4 were medication errors. • After identification of furmedication errors found on LPN-A, LPN-A suspended uncompletion of investigation. • After completion of investigation.	n was medication ollowed up on. and families notified of ther 12/08/2020 by upon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMI	E SURVEY PLETED
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F 755	medication error w 10:58 p.m. however made aware of the A facility document 12/8/20, indicated hydrocodone-aceta scheduled to be ac 12/8/20. The incid medication error w 6:01 p.m. and R2's the medication error R3's Face Sheet p diagnoses included syndrome and maj R3's signed Physic included orders for syndrome) 100 mg a.m., 2:00 p.m. and (antianxiety) 10 mg a.m., 2:00 p.m., and A facility document 12/8/20, indicated gabapentin and Bube administered at incident report furtherror was identified however, R3's provof the medication expenses and subseparation and Bube administered at incident report further awards and subseparation and Bube administered at incident report further awards award	as identified on 12/1/20, at er, R2's provider had not been medication error until 12/8/20. It titled Incident Details dated R2 had not been given her aminophen pain medications Iministered at 2:00 pm. on ent report further indicated the as identified on 12/8/20, at provider had been notified of or on 12/9/20. In titled 11/9/20, indicated R3's dementia, restless leg or depressive disorder. It is an Orders dated 10/9/20, a gabapentin (treat restless leg by mouth 3 times daily at 8:00 d 8:00 p.m., Buspar g by mouth 3 times daily at 8:00 d 8:00 p.m. It titled Incident Details dated R3 had not been given her ispar medications scheduled to 2:00 p.m. on 12/1/20. The ner indicated the medication I on 12/1/20, at 12:25 a.m. vider had not been made aware		5			

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F 755	R4's Face Sheet prediagnoses included disorder. R4's signed Physici included orders for tablet by mouth 1 till A facility document 12/8/20, indicated F Zoloft medication set at 8:00 a.m. on 12/further indicated the identified on 12/1/2 provider had not be medication error under the identified on 12/1/2 provider had not be medication error under the identified on 12/1/2 provider had not be medication error under the identified on 12/1/2 provider had not be medication error under the indication in the medication in the medicating they were 12/1/20, she had not be medicating they were 12/1/20, she had not be medication in the medicating they were 12/1/20, she had not be medication in the m	inted 11/9/20, indicated R4's dementia and anxiety ian Orders dated 7/20/20, Zoloft (antidepressent) 50 mg me daily at 8:00 a.m. titled Incident Details dated R4 had not been given her cheduled to be administered 1/20. The incident report e medication error was 0, at 12:25 a.m. however, R2's een made aware of the still 12/8/20. a.m. licensed practical nurse iewed and stated there had incerns brought to the director egarding LPN-A's failure to s their prescribed medications. ent's medications were being A, however, they were often dication bubble packs, e not given. LPN-B stated on otified the DON of the		555			
	stated photocopies bubble packs had a 12/1/20. LPN-B fur registered nurse (R of all facility medica On 12/8/20, at 11:0	or R1, R2, R3, and R4. LPN-B of the individual medication also been given to the DON on ther stated after this incident, N)-A had completed an auditation carts. 8 a.m. LPN-A stated she had rrors recently and in the past					

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F 755	which included not medications. LPN-with her regarding medication errors von 12/1/20. On 12/8/20, at 12:2 completed audits fc RN-A stated the DC completed the medication correctly administered as proposed audits revealed LP medication correctly RN-A stated in addition pills found on the bocarts. RN-A stated responsible for the R3, and R4. RN-A resident's physician mediation error at they should be upd On 12/8/20, at 12:4 had been notified of evening of 12/1/20, not administered for DON stated a full in completed. The DON been notified of the they were identified unidentified medication card destroyed without of destruction form. Timportant for all medications are supported and the medication card destroyed without of destruction form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form. Timportant for all medications are supported as the medication form.	administering all prescribed A stated the DON had spoken medication administration and which occurred most recently 21 p.m. RN-A stated she had or all facility medication carts. ON had instructed her to dication cart audits due to ications were not being escribed. RN-A stated the N-A had not administered by for R1, R2, R3, and R4. ition, there were unidentified ottom of one of the medication LPN-A was the nurse medication errors for R1, R2, stated she did not know if the has had been notified of the the time of the incidents, but	F 75	55		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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F 755	him other concerns administration, how prior to 12/1/20. The received the report medication accurate investigation which medication cart audiculated on 12/9/20, at 7:14 the DON were both additional medicational medications again not administed R3. The facility policy Modirected staff that remedications in accorder, and in component Regulations. Indicatorushing medicational medic	related to LPN-A's medication vever, there had not been proof e DON stated when he had so of LPN-A not administering ely, he did not compete an should have included dits. a.m. the administrator and interviewed. The DON stated on errors were identified on mately 4:00 p.m. when an ed on LPN-A's medication cart oleted her shift. The DON on errors involved LPN-A once ering medication for R2 and dedication Errors undated, esidents would receive ordance with their physician's liance with State and Federal tions and procedures for	F 75	55			

PRINTED: 02/23/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department o					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag alle number indicated below. In the several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was comple Minnesota Departm facility was found no requirements of 42	rS: n 12/9/20, an abbreviated ted at your facility by the nent of Health (MDH) The ot to be in compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/23/20

TITLE

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		00865	B. WING		12/0	9/2020
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2 000	Continued From pa	ge 1	2 000			
	Complaint H525803 licensing orders we	88C was substantiated. No re issued.				
	Correction (ePoC) a not required at the I State form. Althoug	ed in the electronic Plan of and therefore a signature is pottom of the first page of the h no plan of correction is ed that you acknowledge onic documents.				
2 440	MN Rule 4658.0218 Medications	5 Administration of	2 440			1/22/21
	medications must b part 4658.1325, sub	ts to self-administer be provided as allowed under be part 4. Medications may be as provided under part 6.				
	by: Based on observati review, the facility fa were administered orders for 4 of 4 res	ent is not met as evidenced on, interview, and document ailed to ensure medications in accordance with physician sident (R1, R2, R3, and R4) for cations not being given.		Corrected		
	Findings include:					
	R1's Face Sheet pr diagnoses included	inted 11/9/20, indicated R1's CHF.				
	included orders for (medication to treat potassium in the blo	an Orders dated 11/19/20, potassium chloride-K-Dur or prevent low amounts of bod) 20 meq (milliequivalent) aily at 5:00 a.m., 10:00 a.m., p.m.				

Minnesota Department of Health

STATE FORM 6899 FNCU11 If continuation sheet 2 of 7

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
			A. BUILDING.			С
		00865	B. WING			09/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRANCI	SCAN HEALTH CENT	FR	NESOTA AVE MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 440	A facility document 12/8/20, indicated in potassium chloride scheduled to be ad 12/1/20. The incide medication error was 10:58 p.m., however made aware of the R2's Face Sheet prodiagnoses included HTN. R2's signed Physic included orders for mg (milligram) by multivitamin 1 tables Colace (stool softer times daily at 8:00 at treat fluid build-up of mouth 1 time daily 2 times daily at 12:1 potassium 20 meq a.m., Prednisone (stime daily at 8:00 a stomach acid) 10 m 8:00 a.m., vitamin I time daily at 8:00 a hydrocodone-aceta medication) 7.5-32:8:00 a.m., 2:00 p.m. A facility document 12/8/20, indicated in Lexapro, multivitam K-Dur, Prednisone, medications schedia.m. on 12/1/20. Timedication error was medication error was schedia.m. on 12/1/20. Timedication error was schedia.m.	titled Incident Details dated R1 had not been given her -K-Dur 20 meq medication ministered at 2:00 p.m. on nt further indicated the as identified on 12/1/20, at er, R1's provider had not been medication error until 12/8/20. inted 11/9/20, indicated R2's COPD, major depression and ian Orders dated 11/26/20, Lexapro (antidepressant) 10 nouth 1 time daily at 8:00 a.m., et by mouth daily at 8:00 a.m., her) 200 mg dose by mouth 2 a.m. and 5:00 p.m., Lasix (to due to heart failure) 20 mg by at 12:00 p.m., Tylenol 650 mg 00 p.m. and 8:00 p.m., by mouth 1 time daily at 8:00 steroid) 2.5 mg by mouth 1 m., Prilosec (decreases ng by mouth 1 time daily at 03 5,000 unit tablet by mouth 1 m., and minophen (narcotic pain 5 mg by mouth 3 times daily at 10 mg by mouth 3 times daily at 100 mg by mouth 100 mg by mg by mouth 100 mg by mg b				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00865	B. WING		12/0) 9/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FRANCIS	SCAN HEALTH CENT	=R	NESOTA AVE	ENUE			
	Г	DULUTH,	MN 55802				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 440	Continued From pa	ge 3	2 440				
	made aware of the	medication error until 12/8/20.					
	12/8/20, indicated F hydrocodone-aceta scheduled to be add 12/8/20. The incide medication error wa 6:01 p.m. and R2's the medication error R3's Face Sheet pr diagnoses included syndrome and major	inted 11/9/20, indicated R3's dementia, restless leg or depressive disorder.					
	included orders for syndrome) 100 mg a.m., 2:00 p.m. and	by mouth 3 times daily at 8:00					
	12/8/20, indicated F gabapentin and Bus be administered at incident report furth error was identified	titled Incident Details dated R3 had not been given her spar medications scheduled to 2:00 p.m. on 12/1/20. The er indicated the medication on 12/1/20, at 12:25 a.m. ider had not been made aware rror until 12/8/20.					
	12/8/20, indicated F gabapentin and Bus be administered at incident report furth error was identified	titled Incident Details dated R3 had not been given her spar medications scheduled to 2:00 p.m. on 12/8/20. The er indicated the medication on 12/8/20, at 2:56 p.m., and een made aware of the 12/8/20.					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		00865	B. WING		1	9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVE MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 440	Continued From pa	nge 4	2 440			
	R4's Face Sheet pr	rinted 11/9/20, indicated R4's I dementia and anxiety				
	included orders for	ian Orders dated 7/20/20, Zoloft (antidepressent) 50 mg me daily at 8:00 a.m.				
	12/8/20, indicated F Zoloft medication s at 8:00 a.m. on 12/ further indicated the identified on 12/1/2	titled Incident Details dated R4 had not been given her cheduled to be administered 1/20. The incident report e medication error was 0, at 12:25 a.m., however, not been made aware of the htil 12/8/20.				
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person could review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.					
	TIME PERIOD FOR Twenty-One (21) da					
	(LPN)-B was intervibeen numerous color nursing (DON) readminister resident LPN-B stated resid signed out by LPN-times still in the meindicating they were 12/1/20, she had not medication errors for stated photocopies bubble packs had a	a.m. licensed practical nurse iewed and stated there had neerns brought to the director egarding LPN-A's failure to as their prescribed medications. ent's medications were being A, however, they were often edication bubble packs, a not given. LPN-B stated on otified the DON of the or R1, R2, R3, and R4. LPN-B of the individual medication halso been given to the DON on orther stated after this incident,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
		00865	B. WING		I	C 09/2020						
NAME OF I			DDEEC CITY O	TATE ZID CODE		0.12020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE												
FRANCISCAN HEALTH CENTER DULUTH, MN 55802												
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)						
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE						
2 440	Continued From page 5		2 440									
	registered nurse (RN)-A had completed an audit of all facility medication carts.											
	made medication e which included not medications. LPN-A with her regarding r	8 a.m. LPN-A stated she had rrors recently and in the past administering all prescribed A stated the DON had spoken medication administration and which occurred most recently										
	completed audits for RN-A stated the DC completed the med concerns that mediadministered as preaudits revealed LPN medication correctly RN-A stated in addipills found on the bocarts. RN-A stated responsible for the R3, and R4. RN-A resident's physician	1 p.m. RN-A stated she had or all facility medication carts. DN had instructed her to ication cart audits due to cations were not being escribed. RN-A stated the N-A had not administered y for R1, R2, R3, and R4. tion, there were unidentified of the not of one of the medication LPN-A was the nurse medication errors for R1, R2, stated she did not know if the is had been notified of the he time of the incidents, but atted immediately.										
	had been notified of evening of 12/1/20, not administered for DON stated a full in completed. The DOL LPN-A, and felt at the moment. The DON been notified of the they were identified unidentified medical	2 p.m. the DON verified he f the mediation errors on the which involved medications r R1, R2, R3, and R4. The expecting the had spoken with hat time it was a teachable I stated providers should have medication errors at the time it had been found in one of s, however, they had been										

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DATE OF THE APPROPRIAT			A. BO	JILDING			_						
FRANCISCAN HEALTH CENTER 3910 MINNESOTA AVENUE DULUTH, MN 55802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X50 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENC		00865	B. WI	ING		I							
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DULUTH, MN 55802 DULUTH, MN 55802 ID PROVIDER'S PLAN OF CORRECTION (XE COMPILED COMPILED CAN COMPILED COMP	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED TO THE APPROPRIATE DATE OF THE APPROPRIATE D	FRANCISCAN HEALTH CENTER												
	PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	(X5) COMPLETE DATE							
destroyed without documentation on a medication destruction form. The DON stated it was important for all medications to be administered as ordered. The DON stated staff had brought to him other concerns related to LPN-A's medication administration, however, there had not been proof prior to 12/1/20. The DON stated when he had received the reports of LPN-A not administering medication accurately, he did not compete an investigation which should have included medication cart audits. On 12/9/20, at 7:14 a.m. the administrator and the DON were both interviewed. The DON stated additional medication errors were identified on 12/8/20, at approximately 4:00 p.m. when an audit was completed on LPN-A's medication cart after she had completed her shift. The DON stated the medication errors involved LPN-A once again not administering medication for R2 and R3. The facility policy Medication Errors undated, directed staff that residents would receive medications in accordance with their physician's order, and in compliance with State and Federal Regulations. indications and procedures for crushing medications. The facility policy Notification of Significant Changes last reviewed 1/7/19, directed notification to resident's physician and designate resident representative in the event of a significant change which included a need to alter treatment.	destroyed without of destruction form. To important for all meas ordered. The Do him other concerns administration, how prior to 12/1/20. The received the report medication accuration investigation which medication cart au. On 12/9/20, at 7:14 the DON were both additional medicational medications in accorder, and in compart in medications in accorder, and in compart in medicational medicatio	cumentation on a medications to be administed stated staff had broughlated to LPN-A's medicated to LPN-A's medicated to LPN-A's medicated when he had not been DON stated when he had LPN-A not administed to the had not compete a nould have included as. In the administrator and terviewed. The DON stately 4:00 p.m. when an on LPN-A's medication ted her shift. The DON a terrors involved LPN-A and medication for R2 and dication Errors undated and the shift would receive the shift would receive the shift would receive the shift state and Fed and procedures for the shift of Significant and physician and procedures for the shift would receive the shift state and Fed and physician and procedures for the shift shift and shift would receive the shift state and fed and physician and designed in the event of a	ered ght to ication n proof had ering an and stated on n cart I A once and d, sian's deral	40									

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