

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 19, 2021

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: May 19, 2021

Dear Administrator:

On June 11, 2021, we notified you a remedy was imposed. On July 14, 2021 the Minnesota Department of Health 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 July 1, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 26, 2021 be discontinued as of July 1, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 7, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 1, 2021. 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,

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 June 7, 2021

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: May 3, 2021

#### Dear Administrator:

On May 19, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 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:

Terri 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

Office: (218) 302-6151 Mobile: (218) 766-2720

#### 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 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 August 19, 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 November 19, 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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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.

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: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245258	B. WING			C <b>05/19/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	19/2021	
	SCAN HEALTH CENT	ER		3910 MINNESOTA AVENUE DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs	F 0	00			
F 550 SS=D	abbreviated survey Your facility was for with the requirement for L. The following comp SUBSTANTIATED: H5258044C (MN72F600, F609. H5258045C (MN72F550. H5258046C (MN72F550, F576, F690. The facility's plan of as your allegation of Departments accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an onsite revisit of your validate that substate regulations has been Resident Rights/Ex CFR(s): 483.10(a) (S483.10(a) Resider The resident has a self-determination, access to persons as the self-determination of the self-determination, access to persons as the self-determination of the self-determination, access to persons as the self-determination of the self-determination, access to persons as the self-determination of the self-determination, access to persons as the self-determination of the self-determination of the self-determination, access to persons as the self-determination of the self-determ	2806), with deficiencies cited at 2802), with a deficiency cited at 2797), with deficiencies cited at 2797, with deficience upon the 2797 are facility page of the CMS-2567 ic submission of the POC will tion of compliance.  2802), with deficiencies cited at 2797, with deficiency are compliance upon the 2797, with deficiency are graph of the 2797, with deficiency are graph of the 2797, with deficiency signature is not required at 2797, and	F 5	50		6/27/21	
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

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.

**Electronically Signed** 

06/16/2021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	TIPLE CONSTRUCTION  NG	CON	(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C / <b>19/2021</b>	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802			
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F 550	§483.10(a)(1) A fawith respect and oresident in a manipromotes mainter her quality of life, individuality. The promote the rights §483.10(a)(2) The access to quality of severity of condition must establish an practices regarding provision of service residents regardles §483.10(b) Exercitable The resident has rights as a resident or resident of the §483.10(b)(1) The resident can exercise of the frights and to be sexercise of his or subpart. This REQUIREMI by:  Based on interviet facility failed to en reviewed for dignito wear. In additional promotes and to the sexercise of the sexercise of the reviewed for dignito wear. In additional promotes and to the sexercise of the sexercise of the sexercise of the sexercise of the provided for dignito wear. In additional promotes and the sexercise of the s	acility must treat each resident dignity and care for each ner and in an environment that nance or enhancement of his or recognizing each resident's facility must protect and so of the resident.  The facility must provide equal care regardless of diagnosis, on, or payment source. A facility d maintain identical policies and not transfer, discharge, and the case under the State plan for all less of payment source.  The fights.  The right to exercise his or her not of the facility and as a citizen	F 5	Resident Rights/Exercise of The Administrator and Envi Services Director will oversof this plan of correction, inceducation, auditing and revi	ronmental ee all sections cluding the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C 19/2021
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2021
				3910 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ER		DULUTH, MN 55802		
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F 550	-		F 550			
	residents (R3) revi	ewed for toileting.		materials.		
	Finding include:			R2 is no longer a resident a center. The Administrator and		
	R2's diagnoses ind accident (stroke), a understand or exprand hemiparesis (pody).  R2's admission Mi 3/17/21, indicated impaired. R2's MD assist of one for dr  R2's care plan initineeded assistance	ated on 3/15/21, indicated R2 with dressing. R2's goals were essing and he would be		Environmental Services Director the inventory of linens available Personal laundry inventory revier R8 and was provided more laun necessary.  • All residents have potential impacted by this deficient practice.  • The care center policy on Direviewed by the IDT and no upd needed.  • Administrator and Environm Services Director reviewed inventouse-wide linens for all residen.  • On 5/7/2021 Administrator plinen order.  • Facility par level reviewed for and adjustments were made as	for R8. wed for dry as to be ce. ignity was ates ental ntory of its. ilaced	
	(FM)-D was intervimade ready for be during his stay, we because he didn't also stated she was any gowns availabin tears, he was for movement. FM-D wearing only an incoclean clothes, a gowns.  R8's Face Sheet presses incompairment, and accompanies of the stay	5 p.m. R2's family member ewed and stated that R2 was d on at least one occasion aring only an incontinence brief have any clean clothes. FM-D s told the facility did not have le. FM-D stated she found R2 reed to sit in his own bowel stated she would find R2 in bed continent brief because he had and the facility had no clean rinted on 5/19/21, indicated cluded mild cognitive dult failure to thrive.		<ul> <li>Administrator educated         Environmental Services Director         maintaining proper par levels.</li> <li>Environmental Services Director         audit linen par levels weekly and         Administrator will be auditing line         levels monthly starting on 6/11/2</li> <li>Linens will be ordered as needed.</li> <li>Audit results will be brought         QAPI committee quarterly for refurther recommendations.</li> <li>Based on surveyor interview documentation review facility fait ensure a bathroom was accessing resident R3.</li> <li>All residents within the facility potentially be impacted by this personer.</li> <li>R3 currently is not a resident.</li> </ul>	ector will len par 021. eded. to the view and led to ble to ty could ractice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (COMPI		PLETED				
		245258	B. WING			C 1 <b>9/2021</b>
NAME OF	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP		13/2021
FRANCIS	SCAN HEALTH CEN	TER		3910 MINNESOTA AVENUE DULUTH, MN 55802		
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F 550	was totally dependence of the could not find any stated the facility hincluding gowns.  -at 1:43 p.m. envirinterviewed. ES-Coutside facility with Wednesday, and On 5/19/21, at 10: (DON) was intervined to sleep in pajama.	dent on staff for dressing.  iated on 2/19/18, indicated R8 with dressing. R8's goal was be with dressing and would be sed daily.  In a ssistant (NA)-E was a stated that R8 was put to be discontinent brief because she less. The facility did not have any wear.  It is interviewed. NA-E stated she dents in bed wearing only an ecause they didn't have clean owns to put on them. NA-E to bed wearing just an le night before because she clothing or a gown. NA-E had been very short on linens, we stated laundry was done at an in deliveries on Monday, Friday.  28 a.m. the director of nursing lewed. The DON stated it was lave a resident in only an the resident's preference was la's or a gown.  Printed 5/19/21, indicated R3's led spastic hemiplegia (muscles labody in a constant state of ling left non-dominant side, and	F 5	the facility.  Assessments will be coresidents that use tub/show to determine if the use of the still appropriate by the Nurse Resident preferences will be Adjustments to resident calcompleted as needed by the Manager.  All staff will be educated Dignity in SNF created by the Health Care Association (A)  Resident preferences and as request resident by the Social Service designee.  Bathroom use/preferences are met.  Results will be brought to quarterly QAPI committee recommendations if needed.	wer bathrooms hat bathroom is se Manager. De reviewed. The plans will be the Nurse and One Resident the American AHCA) will be the prices Director or the audits will 2 weeks and the resident the and reviewed the prices of the plant of the prices of the prices of the prices of the plant of the prices of the plant of the prices of the plant of the prices of the pric	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245258		1 ' '	PLE CONSTRUCTION  G	COM	C (X3) DATE SURVEY		
		245258	B. WING _		ı	) 19/2021		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802				
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F 550	Continued From pa	age 4	F 55	0				
	was cognitively intaincontinent of urine bowel. R3's MDS is extensive assistant. On 4/24/21, at 4:48 indicated R3 was using the tub/show being able to use the rooms were in use. On 5/17/21, at 2:38 stated she was not her shared room, if through the door use a commode be transfer and do not she was supposed tub/shower rooms, locked, the floors were not available the room for bathin caused her to have make her feel badat 12:26 p.m. NAstated R3's wheeld bathroom door. NA about 10 minutes to or tub room. NA-B would alarmed if sl had an accident sh incontinent brief.	OS dated 2/15/21, indicated R3 act, was occasionally and always continent of indicated she required be with toileting and dressing.  B. a.m. a progress note appet about the difficulty in the room bathrooms, and not the bathroom because the by other residents.  D. p.m. R3 was interviewed. R3 able to use the bathroom in the rewheelchair was too wide to the cause they move during allow for privacy. R3 stated to use the bathrooms in the but the rooms were kept were frequently wet, and they if another resident was using ag/showering. R3 stated this accidents, and this would and she would sometimes cry.  B. was interviewed. NA-Behair would not fit through the the stated it would take R3 on wheel herself to the shower stated the door was locked, it the tried to open it, and if she are would need to bring an ith her as there were no wer and tub rooms.						
		s interviewed. NA-E stated she						

	ATEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		COV	(X3) DATE SURVEY COMPLETED		
		245258	B. WING _			C / <b>19/2021</b>
	PROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP COD 3910 MINNESOTA AVENUE DULUTH, MN 55802	•	10/2021
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	couldn't get into the because the door wood on 5/19/21, at 10:2 interviewed and stanot always get to the intime to prevent be DON stated this was at 11:52 a.m. the at The administrator swhen someone who incontinent because bathroom in time.  The facility docume Compliance Relate Nursing Facilities of Health Care Associ maintain or improved dress, and groom; the eat; and use speed functional communicational comm	oble" occasions because she shower/tub bathrooms vas locked.  8 a.m. the DON was ted he was aware R3 could e shower/tub room bathroom eing incontinent of urine. The s a dignity issue for R3.  dministrator was interviewed. tated it was a dignity issue o was continent of bladder was e they could not get to a set they could not get to a set of the American ation undated, directed staff to the his or her abilities to bathe, transfer and ambulate; toilet; h, language, or other ication system.	F 55			6/27/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245258	B. WING		05	C / <b>19/2021</b>
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP O 3910 MINNESOTA AVENUE DULUTH, MN 55802		
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F 576	facility, including r (i) A telephone, in (ii) The internet, to facility; and (iii) Stationery, po the ability to send §483.10(g)(8) The and receive mail, and other materia resident through a service, including (i) Privacy of such with this section; a (ii) Access to stati implements at the §483.10(g)(9) The reasonable acces electronic commu- video communica (i) If the access is (ii) At the resident expense is incurre access to the resi (iii) Such use mus law. This REQUIREMI by: Based on intervie facility failed to en residents on Satu affect all residents Findings include:  On 5/18/21, at 12 was interviewed.	reasonable access to: cluding TTY and TDD services; to the extent available to the stage, writing implements and mail.  resident has the right to send and to receive letters, packages is delivered to the facility for the ameans other than a postal the right to: communications consistent and onery, postage, and writing resident's own expense.  resident has the right to have so and privacy in their use of inications such as email and tions and for internet research, available to the facility 's expense, if any additional ed by the facility to provide such dent.  St comply with State and Federal ENT is not met as evidenced  awand document review, the issure mail was delivered to rdays. This had the potential to	F 5	Right to forms of community privacy The Administrator and Activity will oversee all sections of correction, including the eduditing and review of thos SW-A and AA-A were educated by a correction of the correcti	vities Director this plan of ucation, e materials. educated on Saturdays. facility could	

AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′	2) MULTIPLE CONSTRUCTION (X3) BUILDING		3) DATE SURVEY COMPLETED	
		245258	B. WING _			C 19/2021
	ROVIDER OR SUPPLIER	≣R		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	1 00/	13/2021
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F 576	activities director or go through the mail should be delivered was done to ensure important mail. On 5/19/21, at 9:56	ge 7 until Monday. AA-A stated the the social worker would then, and determine what mail to residents. AA-A stated this eresidents didn't throw out any a.m. the social worker ewed. SW-A verified mail was	F 57	<ul> <li>Upon admission resident is as how they would like their mail to be handled. Choices are: 1. Receive 2. Receive personal mail only; bus mail to responsible party. 3. Activit read personal mail; business mail read by responsible party. 4. All m to responsible party.</li> <li>On 5/19/2021 Administrator ed</li> </ul>	e all mail. siness ties to to be ail goes	
	not delivered to res stated this was to e to be be forwarded to residents and ac stated this was a vicated this was a vicated. The Dowere not receiving a stated this was a vicated this	idents on Saturdays. SW-A nsure mail that was supposed to families was not delivered cidentally thrown away. SW-A		Activities Director regarding mail procedure.  • All Activities staff educated as preference for mail delivery and procedure, including mail delivery Saturdays.  • Activity Director will conduct ra audits on Monday's to ensure mai passed out per procedure and preferences starting on 5/24/2021  • All audit results will be brough reviewed with quarterly QAPI comfor further recommendations.	to on andom I was . t and	
	provided. Safe/Clean/Comfor CFR(s): 483.10(i)(1  §483.10(i) Safe Env The resident has a comfortable and ho	vironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely.	F 58	34		6/27/21
		e, clean, comfortable, and				

CLIVILI	13 I ON MEDICANE	- WINDOWN SELVICES			<u> </u>	VID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245258	B. WING	ì			C 19/2021
NAMEOF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/	19/2021
NAME OF F	PROVIDER OR SUPPLIER						
FRANCIS	SCAN HEALTH CENT	FR		39	910 MINNESOTA AVENUE		
	JOAN HEALIN GENT			D	OULUTH, MN 55802		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N .	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
					DEFICIENCY)		
F 584	Continued From pa	age 8	F :	584			
	homelike environm	ent, allowing the resident to					
	use his or her pers	onal belongings to the extent					
	possible.						
	(i) This includes en	suring that the resident can					
	receive care and se	ervices safely and that the					
	physical layout of the	he facility maximizes resident					
	independence and	does not pose a safety risk.					
	(ii) The facility shall	l exercise reasonable care for					
	the protection of the	e resident's property from loss					
	or theft.						
		ekeeping and maintenance					
		/ to maintain a sanitary, orderly,					
	and comfortable in	terior;					
	0.400, 40/;\/Q\ OL						
		n bed and bath linens that are					
	in good condition;						
	\$492.40(i)(4) Drive	to algost appear in each					
		te closet space in each					
	resident room, as s	specified in §483.90 (e)(2)(iv);					
	\$483 10(i)(5) Adea	uate and comfortable lighting					
	levels in all areas;	date and connortable lighting					
	iovois iii aii albas,						
	8483 10(i)(6) Comf	fortable and safe temperature					
	( ) ( )	tially certified after October 1,					
		n a temperature range of 71 to					
	81°F; and	ir a temperature range or 7 1 to					
	or i , and						
	8483 10(i)(7) For th	ne maintenance of comfortable					
	sound levels.	io maintonanos er comiertable					
		NT is not met as evidenced					
	by:	14. IS NOT MOT US OVINCTION					
		v and document review, the			Safe/Clean/Comfortable/Homelike		
		sure resident clothing was			Environment		
		ilable for 2 of 4 residents (R2,			The Administrator and Environmen	tal	
		nen use. In addition, the facility			Services Director will oversee all se		
	ialieu lo erisure lac	cility gowns were available.			of this plan of correction, including		
					education, auditing and review of the	iose	

F 584 Continued From page 9 Findings include:  R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).  R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing.  R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing and he would be appropriately dressed daily.  F 584  F 584  F 584  F 584  R 2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary.  • All residents have potential to be impacted by this deficient practice.  • The care center policy on Dignity was reviewed by the IDT and no updates needed.  • Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents.  • On 5/7/2021 Administrator placed	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802			245258	B. WING			
CALCIDETION   CALCIDETIC	NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL	•	
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION DATE      F 584	EDANOI	20 411 115 41 711 0517	·		3910 MINNESOTA AVENUE		
F 584  Continued From page 9 Findings include:  R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).  R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing.  R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing and he would be appropriately dressed daily.  F 584  F 584 F 584 F 584 F 584 F 584 F 584 F 584 F 584 F 584 F 584 F 584 F 588 F 2is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary.  • All residents have potential to be impacted by this deficient practice.  • The care center policy on Dignity was reviewed by the IDT and no updates needed.  • Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents.  • On 5/7/2021 Administrator placed	FRANCE	SCAN HEALTH CENT	EK		DULUTH, MN 55802		
Findings include:  R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).  R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing.  R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily.  materials.  • R2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary.  • All residents have potential to be impacted by this deficient practice.  • The care center policy on Dignity was reviewed by the IDT and no updates needed.  • Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETION
R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive.  R8's quarterly MDS dated 3/24/21, indicated R8 was totally dependent on staff for dressing.  R8's care plan dated 2/19/18, indicated R8 required assistance with dressing. The goal on 2/14/20, was R8 would be appropriately dressed daily.  On 5/17/21, at 2:35 p.m. family member (FM)-D was interviewed. FM-D stated the facility staff would leave R2 lying in bed with only his incontinence brief on because he had no clean clothes.  -at 12:44 nursing assistant (NA)-E was interviewed. NA-E stated she had observed residents in bed wearing just an incontinent brief	F 584	Findings include:  R2's Face Sheet p R2's diagnoses includers accident (stroke), a understand or expland hemiparesis (p body).  R2's admission Mi 3/17/21, indicated impaired, and required assistance to participate in dreappropriately dress R8's Face Sheet p R8's diagnoses included impairment, and accept accept a comparticipate in dreappropriately dress R8's Face Sheet p R8's diagnoses included impairment, and accept accept a comparticipate in dreappropriately dress R8's Face Sheet p R8's diagnoses included impairment, and accept	rinted on 5/19/21, indicated cluded cerebrovascular aphasia (loss of the ability to ress speech), and hemiplegia paralysis of one side of the cluded R2 was severely cognitively gired assistance with dressing.  Bed 3/15/21, indicated R2 with dressing. R2's goals were essing and he would be seed daily.  Finited on 5/19/21, indicated cluded mild cognitive dult failure to thrive.  Bed 3/24/21, indicated R8 ent on staff for dressing.  Bed 2/19/18, indicated R8 ewith dressing. The goal on ould be appropriately dressed  Dep.m. family member (FM)-D M-D stated the facility staffing in bed with only his on because he had no clean desistant (NA)-E was stated she had observed	F 5.	<ul> <li>R2 is no longer a resident center. The Administrator and Environmental Services Direct the inventory of linens available Personal laundry inventory reviewed more launcessary.</li> <li>All residents have potential impacted by this deficient praction of the care center policy on reviewed by the IDT and no unneeded.</li> <li>Administrator and Environ Services Director reviewed in house-wide linens for all resident of the content of the care in house-wide linens for all resident of the content of the conte</li></ul>	tor reviewed le for R8. viewed for undry as al to be ctice. Dignity was pdates mental ventory of ents. r placed for all linen as needed. tor on Director will and linen par 1/2021. needed. ht to the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245258	B. WING				C <b>19/2021</b>
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COI 3910 MINNESOTA AVENUE DULUTH, MN 55802	DE		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD	BE	(X5) COMPLETION DATE
F 600 SS=D	because they didn't on them. NA-E stat wearing just a brief could not find any or gown. NA-E stated short on linens, inclinate and interviewed. ES-C soutside facility with Wednesday, and FO 19/21, at 10:2 (DON) was interviewed aware for two saying there was not a 11:52 a.m. the administrator of the past two weeks was not enough line Free from Abuse ar CFR(s): 483.12(a)( §483.12 Freedom f Exploitation The resident has the neglect, misapprop and exploitation as includes but is not I corporal punishmer any physical or chetreat the resident's §483.12(a) The face §483.12(a)(1) Not the same could be sufficiently as inclinated the same could be sufficiently as inclinated the resident's §483.12(a)(1) Not the same could be sufficiently as inclinated the same could be sufficiently as i	thave clothes or gowns to put ted she had put R8 to bed the night before because she of their clothing or a facility the facility had been very luding facility gowns.  Inmental service (ES)-C was stated laundry was done at an deliveries on Monday, friday.  R8 a.m. the director of nursing ewed. The DON stated he had to three weeks that staff were of enough linen.  Administrator was interviewed. Stated she had been aware for that staff were saying there en.  Ind Neglect (1)  From Abuse, Neglect, and  The right to be free from abuse, oriation of resident property, defined in this subpart. This limited to freedom from the involuntary seclusion and emical restraint not required to medical symptoms.	F 5				6/27/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	COME	SURVEY PLETED
		245258	B. WING		05/1	) 19/2021
NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 001	
				3910 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ER		DULUTH, MN 55802		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG	·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 600	Continued From pa	· •	F 60	0		
		on; NT  is not met as evidenced				
	by: Based on interviev	v and document review, the		Free from Abuse and Neglect		
		ure residents were free from		The Administrator and Director of	f Nursing	
		allegation of staff to resident		will oversee all sections of this pl		
	abuse for 1 of 4 re	viewed for abuse.		correction, including the education auditing and review of those materials.		
	Findings include:			Based on interviews, docume reviewed by surveyor and report		
	R1's Disease Diagi	nosis & Allergies list printed on		submitted to state agency RN-B	was	
	5/19/21, indicated I	R1 had diagnoses which		observed sometime in March or	April of	
		ed dementia without behavioral		2021 forcing resident R-1 to drinl		
	disturbance.			<ul> <li>All residents within the facility potentially be impacted by this pr</li> </ul>		
	R1's quarterly Mini	mum Data Set (MDS) dated		<ul> <li>Resident interviews were cor</li> </ul>		
		R1 was severely cognitively		by social services director asking		
	impaired, and was	able to eat independently.		had ever been forced "to take medications, food or liquids again	nst their	
		ed 3/31/21, indicated staff was		will". All residents expressed that		
		ssist and cues with meals as		never happened to them and exp	ressed	
	needed.			no further concerns.  • IDT reviewed Maltreatment		
	A report submitted	to the State Agency (SA) on		Prohibition Policy with no change	s noted.	
	5/12/21, indicated r	registered nurse (RN)-B was		<ul> <li>On 5/20/2021 1:1 Education</li> </ul>		
		e in March or April of 2021,		to staff member RN-B on the		
	•	juice. The report indicated they		maltreatment prohibitions policy		
		1 needed to drink, and if she A would make sure she drank.		assisting resident with taking ora medications, food and liquids and		
		d holding R1's mouth forcing it		honoring resident wishes when re		
		he juice down R1's throat. It		those services by Director of Nur	_	
	was reported R1 so	creamed, choked, and lashed		<ul> <li>On 5/19/2021 House wide Lie</li> </ul>	censed	
		The reporter stated she told		Nursing education provided on the		
	staff present about	the incident.		assistance when offering residen	ts	
	On 5/18/21 at 2:14	p.m. RN-B was interviewed.		<ul><li>medications, food and liquids.</li><li>Audits will be performed on t</li></ul>	he nroner	
		as had to push fluids with R1,		administration of medications, for		
		I put her hand on the back of		liquids and process to be used by		
	R1's head and force			then the resident refuses those it		

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE  3910 MINNESOTA AVENUE DULUTH, MN 55802  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 600  Continued From page 12  On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The administrator was interviewed. The administrator stated it would be abuse if a staff member prevented a resident from moving their head and forced them to drink fluids.  STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (			245258	B. WING				
F 600  Continued From page 12  On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The administrator was interviewed. The administrator stated it would be abuse if a staff member prevented a resident from moving their head and forced them to drink fluids.  (EACH DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 600  2x/week X4 weeks and then 2X/month X 2 months starting on 5/20/2021.  • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.			ER	3910 MINNESOTA AVENUE				10/2021
2x/week X4 weeks and then 2X/month X 2 months starting on 5/20/2021.  2x/week X4 weeks and then 2X/month X 2 months starting on 5/20/2021.  All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.  -at 11:52 a.m. the administrator was interviewed. The administrator stated it would be abuse if a staff member prevented a resident from moving	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETION DATE
The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.	F 609	On 5/19/21, at 10:2 (DON) was intervie be physical abuse i resident from movii to drink fluids.  -at 11:52 a.m. the a The administrator's staff member preventheir head and force.  The facility policy Mareviewed/amended willful infliction of in confinement, intimic resulting physical has Reporting of Allege CFR(s): 483.12(c) (Section 1988) 12(c) (Section 1988) 12(c	28 a.m. the director of nursing ewed. The DON stated it would if a staff member prevented a ng their head and forced them administrator was interviewed. Stated it would be abuse if a cented a resident from moving ed them to drink fluids.  Maltreatment Prohibition 12/19/18, defined abuse as the njury, unreasonable dation, or punishment with narm, pain, or mental anguish. In dividual violations 1)(4)  In the to allegations of abuse, in, or mistreatment, the facility are that all alleged violations eglect, exploitation or ding injuries of unknown propriation of resident property, diately, but not later than 2 gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve esult in serious bodily injury, to fi the facility and to other to the State Survey Agency and	F6		2x/week X4 weeks and then 2X/mc 2 months starting on 5/20/2021.  • All audit results will be brought reviewed with quarterly QAPI comm	and	6/27/21

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C	
		245258	B. WING			: 1 <b>9/2021</b>
	PROVIDER OR SUPPLIER  SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	accordance with St procedures.  §483.12(c)(4) Repositive stigations to the designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to reposit 4 residents (R1)  Findings include:  R1's Disease Diagret 5/19/21, indicated 1 included unspecified disturbance.  R1's quarterly Minit 3/31/21, indicated 1 impaired, and was R1's care plan date to provide set up as needed.  A report submitted 5/12/21, indicated 1 observed sometime forcing R1 to drink heard RN-B say R1 couldn't drink, RN-2 couldn't drink,	ate law through established	F 609	Reporting of Alleged Violations The Administrator and Director of will oversee all sections of this pla correction, including the education auditing and review of those mate • R1 abuse allegation was repo 5/19/2021 to the State Agency (SA Tracking ID #342025 • All residents within the facility potentially be impacted by this pra • All allegations of abuse will be reported timely to the Administrato Facility will report timely and repor according to facility policy and state federal guidelines. • Maltreatment Reporting Guide policy was reviewed by the Social Services Director, Director of Nurs Administrator regarding reporting allegations of abuse. • All staff have been educated of Maltreatment Reporting Guideline by the Administrator or designee, regarding reporting immediately to Administrator any alleged abuse. • Audits will be completed on a	n of in, rials. rted on in items in ite	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245258	B. WING				C 19/2021
NAME OF F	PROVIDER OR SUPPLIER	l		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	ER			10 MINNESOTA AVENUE		
				DU	ULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609 F 690 SS=D	out with her arms. staff present about On 5/18/21, at 2:14 was interviewed. R push fluids with R1 back of her head a On 5/18/21, at 2:14 RN-B stated she had atted she had atted she had R1's head and force. The facility policy of the facility policy of the reviewed/amended willful infliction of in confinement, intimit resulting physical of the policy directed soon as possible, after the allegation Bowel/Bladder Inconfinement (S): 483.25(e) (1) The resident who is confined the confinement of the policy directed soon as possible, after the allegation Bowel/Bladder Inconfinement (S): 483.25(e) (1) The resident who is confined the policy directed soon as possible, after the allegation Bowel/Bladder Inconfinement (S): 483.25(e) (1) The resident who is confined the president who is	The reporter stated she told the incident.  I p.m. registered nurse (RN)-B N-B stated she has had to , she puts her hand on the nd forced her to drink.  I p.m. RN-B was interviewed. as had to push fluids with R1, I put her hand on the back of ed her to drink.  Maltreatment Prohibition 12/19/18, defined abuse as the njury, unreasonable dation, or punishment with earm, pain, or mental anguish. staff to report immediately as put not later than two hours is made.  Intercept the continence, Catheter, UTI (1)-(3)  Thence.  facility must ensure that notinent of bladder and bowel on	F 6		Director will review copies of conce forms and reporting checklist with Administrator. Administrator will revidocumentation for potential abuse a neglect and timely reporting to SA.  • Administrator will audit all allegabuse complaints to ensure that the been reported timely to the SA on a on-going basis starting on 5/19/202.  • All audit results will be brought reviewed with quarterly QAPI common for further recommendations.	riew all and ed ey have in 11.	6/27/21
	maintain continence condition is or becondition is or becond not possible to mai §483.25(e)(2)For a incontinence, base comprehensive assensure that-	resident with urinary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245258	B. WING			1	19/2021
	PROVIDER OR SUPPLIER			3910 MINN	DRESS, CITY, STATE, ZIP CODE ESOTA AVENUE MN 55802	1 33	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO FACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	indwelling catheter resident's clinical of catheterization was (ii) A resident who indwelling catheter is assessed for rer as possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary tracontinence to the establishment of t	is not catheterized unless the condition demonstrates that is necessary; enters the facility with an or subsequently receives one moval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder te treatment and services to ct infections and to restore	F 6	Bowe UTI The Ad will ove correc auditin  Ba docum ensure reside All potent R3 the fac	I residents within the facility of ially be impacted by this practed by this practed by this practed in the currently is not a resident with the contract of t	Nursing n of , rials. and d to e to could ctice. within	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245258	B. WING		C 		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE  3910 MINNESOTA AVENUE  DULUTH, MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	assistance with trar MDS further indicated incontinent of bladd R3's care plan dated was to not decline it care plan directed and offer assistanch hours and as needed. On 4/24/21, at 4:48 indicated R3 was using the tub/shower sometimes not able other residents were on 5/17/21, at 2:35 stated she was not her room, her whee facility's solution was her room. R3 did not solution, not enough have potential to sleacility said she coushower room or the stated the rooms we showers or baths, at R3 stated the room in use, the key not a wheelchair, and the someone tried to opstated if she could in have an accident.  On 5/18/21, at 7:17 was interviewed. R1 did not fit into the bepart of R3's therapy.	d 2/8/21, indicated R3's goal bladder continence. The staff to encourage fluid intake, e to toilet every two to three	F6	068	residents that use tub/shower bath to determine if the use of that bathr still appropriate by the Nurse Mana Resident preferences will be review Adjustments to resident care plans completed as needed by the Nurse Manager.  • All staff will be educated on Re Dignity in SNF created by the Amer Health Care Association (AHCA)  • Resident preferences will be discussed at residents quarterly ca conference and as requested by the resident by the Social Services Dire designee.  • Bathroom use/preference audit be conducted 3x/week for 2 weeks weekly thereafter to ensure resident preferences are met.  • Results will be brought and revito quarterly QAPI committee for fur recommendations if needed.	room is ger. wed. will be sident rican re e ector or ts will and at iewed	

	OF DEFICIENCIES OF CORRECTION	L' IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245258	B. WING				C / <b>19/2021</b>
	PROVIDER OR SUPPLIER			3910	EET ADDRESS, CITY, STATE, ZIP CODE D MINNESOTA AVENUE LUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	-at 12:26 p.m. NA-stated R3's wheeld bathroom door. NA about 10 minutes to or tub room. NA-B would alarmed if shad an accident shwith her as there wand tub rooms.  -at 12:44 NA-E wa witnessed R3 have episodes on "multicouldn't get into the because the door would couldn't get into the because the door wouldn't get into the because the door would not alway bathroom in time to urine.  -at 2:14 p.m. RN-E she was aware that because she could time.  The facility docume Compliance Relate Nursing Facilities of Health Care Association or improving the state of the province of	B was interviewed. NA-B chair would not fit through the A-B stated it would take R3 o wheel herself to the shower stated the door was locked, it he tried to open it, and if she he would need to bring a brief were no supplies in the shower stated she he bladder incontinence ple" occasions because she he shower/tub bathrooms was locked.  228 a.m. the director of nursing lewed. The DON was aware that was get to the shower/tub room to prevent being incontinent of a was interviewed. RN-B stated at R3 was incontinent of urine lin't get into the bathroom on the lest Practices For led to Resident Dignity In Skilled created by The American station undated, directed staff to be his or her abilities to bathe, transfer and ambulate; toilet; ch, language, or other	Fé	690			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 7, 2021

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

Re: State Nursing Home Licensing Orders

Event ID: VVZL11

#### Dear Administrator:

The above facility was surveyed on May 17, 2021 through May 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

> Terri 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

Office: (218) 302-6151 Mobile: (218) 766-2720

You may reguest a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any 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: 06/25/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00865	B. WING		<b>05/1</b>	) 9/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVI 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
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 of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance. re-inspection with a	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny 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.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction ye	rS: n 5/19/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				

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

06/16/21 **Electronically Signed** 

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00865	B. WING			C <b>19/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS. CITY. S	STATE, ZIP CODE		
			INESOTA AVE	,		
FRANCIS	SCAN HEALTH CENT	=R	, MN 55802			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	The following comp SUBSTANTIATED:	laint were found to be				
	H5258044C (MN72 issued at 626.557 SH5258045C (MN72 issued at 144.651 SH5258046C (MN72 issued at 144.651 SH525804C (MN72 issued at 144.651 SH525804C (MN72 issued at 146.651 SH525804C (MN72 issued at 144.651 SH5264C (MN72 issued a	802) with a licensing order Subd 14 797) with a licensing order Subd 14, 4658.0520 Subp 2 A, and the subd 14, 4658.0520 Subp 2 A, are to f Health is documenting. Correction Orders using ag numbers have been ot a state statutes/rules for the assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the training the state of the state o				
	as evidence by." For are the Suggested I Time Period for Cor	tement, "This Rule is not met ollowing the surveyor's findings Method of Correction and rrection. participate in the electronic				
	receipt of State lice the Minnesota Depa Informational Bullet	nsure orders consistent with artment of Health in 14-01, available at				
	n/infobulletins/ib14_ orders are delineate	state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota Ith orders being submitted to				
	you electronically. As is necessary for State enter the word "CO available for text. You	Although no plan of correction ate Statutes/Rules, please RRECTED" in the box bu must then indicate in the ensure process, under the				

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 2 of 18

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			SURVEY LETED		
			A. BUILDING:			,		
		00865	B. WING			9/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ADDRESS, CITY, STATE, ZIP CODE					
FRANCIS	SCAN HEALTH CENT	FR	IINNESOTA AVENUE TH, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE		
2 000	be corrected prior to the Minnesota Depais enrolled in ePOC	ge 2 I date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of	2 000					
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail  Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored.  This MN Requirement is not met as evidenced by:  Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility.  Findings include:  On 5/18/21, at 12:54 p.m. activities aide (AA)-A was interviewed. AA-A stated on the weekend, mail would be placed in the conference room, and would remain there until Monday. AA-A stated the activities director or the social worker would then go through the mail, and determine what mail should be delivered to residents. AA-A stated this		2 385	Corrected		6/27/21		
	On 5/19/21, at 9:56	a.m. the social worker						

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		,		
		00865	B. WING			9/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVI 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 385	not delivered to res stated this was to e to be be forwarded to residents and ac stated this was a virulated to residents and ac stated this was a virulated. The Dowere not receiving stated this was a virulated this was	ewed. SW-A verified mail was idents on Saturdays. SW-A ensure mail that was supposed to families was not delivered cidentally thrown away. SW-A	2 385				
2 835	, ,	O Subp. 2 A Adequate and re; Criteria	2 835			6/27/21	
	Subp. 2. Criteria fo	or determining adequate and					

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 4 of 18

NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3910 MINNESOTA AVENUE DULUTH, MN 55802	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  FRANCISCAN HEALTH CENTER  3910 MINNESOTA AVENUE				7 20.22 10.			;		
FRANCISCAN HEALTH CENTER 3910 MINNESOTA AVENUE			00865	B. WING					
FRANCISCAN HEALTH CENTER	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
	FRANCI	SCAN HEALTH CENT	FR		ENUE				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE		
2 835  Continued From page 4 proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.  This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a bathroom was accessible to prevent incontinence for 1 of 4 residents (R3) reviewed for bladder incontinence.  Finding include:  R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke) of left mid cerebral artery.  R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, and required extensive assistance with transfers and toilet use. R3's MDS further indicated she was occasionally incontinent of bladder.  R3's care plan dated 2/8/21, indicated R3's goal was to not decline in bladder continence. The care plan directed staff to encourage fluid intake, and offer assistance to toilet every two to three hours and as needed.  On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower bathrooms. R3 was	2 835	proper care. The dadequate and proper vidence of adequate and proper evidence of adequate considerate treatments be respected and some support of the series	criteria for determining er care include: ate care and kind and tent at all times. Privacy must afeguarded.  ent is not met as evidenced and document review, the ure a bathroom was ent incontinence for 1 of 4 ewed for bladder incontinence.  Tinted 5/19/21, indicated R3's a spastic hemiplegia (muscles body in a constant state of ng left non-dominant side, and (stroke) of left mid cerebral  OS dated 2/15/21, indicated R3 and extensive and required extensive and toilet use. R3's ated she was occasionally der.  End 2/8/21, indicated R3's goal in bladder continence. The staff to encourage fluid intake, are to toilet every two to three ed.  Starm. a progress note pset about the difficulty in	2 835					

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 5 of 18

Millinesc	ita Department of He	ain	1			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						:
		00865	B. WING		05/19/2021	
NAME OF I		CTDEET AD		STATE ZID CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENTI	FR	NESOTA AVE	ENUE		
	Г	<u> </u>	MN 55802			
(X4) ID	_	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 835	Continued From pa	age 5	2 835			
2 000	Continued From pa		2 333			
	0 = 11=101 100=					
		p.m. R3 was interviewed. R3				
		able to use the bathroom in				
	•	elchair was too wide. The				
		as for her to use a commode in				
		ot find this a satisfactory h privacy and the commodes				
		lide during transfers. The				
		ild use the bathrooms in the				
		bathroom in the tub room. R3				
	stated the rooms were frequently in use for					
		and the floors were often wet.				
		s were kept locked when not				
	in use, the key not a	accessible for a person in a				
		doors were alarmed if				
		pen the door without a key. R3				
		not get there in time she would				
	have an accident.					
	On 5/19/21 at 7:17	a m. registered pures (PN) A				
		a.m. registered nurse (RN)-A N-A stated it R3's wheelchair				
		athroom, she stated it was				
		to be able to get herself to				
		oom to discharge to her home				
	safely.					
	-at 12:26 p.m. NA-E	B was interviewed. NA-B				
		hair would not fit through the				
		-B stated it would take R3				
		wheel herself to the shower				
		stated the door was locked, it				
		e tried to open it, and if she				
		e would need to bring a brief				
	and tub rooms.	ere no supplies in the shower				
	and tub rooms.					
	-at 12:44 NA-F was	s interviewed. NA-E stated she				
		bladder incontinence				
		ole" occasions because she				
		shower/tub bathrooms				

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 6 of 18

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00865	B. WING		05/1	9/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENTI	-R	NESOTA AVI MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 835	Continued From pa	ge 6	2 835			
	because the door w	/as locked.				
	(DON) was interview R3 could not always	28 a.m. the director of nursing wed. The DON was aware that s get to the shower/tub room prevent being incontinent of				
	she was aware that	was interviewed. RN-B stated R3 was incontinent of urine n't get into the bathroom on				
	Compliance Relate Nursing Facilities of Health Care Associ maintain or improve dress, and groom; to	ent Best Practices For d to Resident Dignity In Skilled reated by The American ation undated, directed staff to e his or her abilities to bathe, transfer and ambulate; toilet; h, language, or other ication system.				
	The Director of Nur develop, review, an procedures to ensu access to bathroom incontinence. The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: sing or designee could d/or revise policies and re residents have ready n facilities to prevent sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 7 of 18

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING.			,
		00865	B. WING			9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	FR	NESOTA AVI 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21670	Continued From pa	nge 7	21670			
21670	MN Rule 4658.140	5 A.B.C.D. Resident Units	21670			6/27/21
	resident:  A. A bed of proconvenience of the mattress, and clear weather and reside condition. Each be bedspread. A mois mattress cover musconfined to bed and Rollaway type beds not be used.  B. A chair or pl than the bed.  C. A place adjapersonal possession with a drawer.  D. Clean bath often as needed.  E. A bed light convenience of the mas needed.	per size and height for the resident, a clean, comfortable bedding, appropriate for the ent's comfort, that are in good at must have a clean sture-proof mattress or set be provided for all residents d for other beds as necessary. So, cots, or folding beds must acce for the resident to sit other accent or near the bed to store ons, such as a bedside table linens provided and of an e needs of the resident while ident chair				
	by: Based on interview facility failed to ens laundered and avai R8) reviewed for lin	ent is not met as evidenced and document review, the ure resident clothing was lable for 2 of 4 residents (R2, nen use. In addition, the facility illity gowns were available.		Corrected		
	Findings include:					
	R2's diagnoses inc	rinted on 5/19/21, indicated luded cerebrovascular uphasia (loss of the ability to				

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 8 of 18

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00865	B. WING			C <b>19/2021</b>
	PROVIDER OR SUPPLIER	FR 3910 MINI	DRESS, CITY, S NESOTA AVE MN 55802	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21670	understand or exprand hemiparesis (pbody).  R2's admission Mir 3/17/21, indicated Fimpaired, and required assistance to participate in dreappropriately dress.  R8's Face Sheet pr R8's diagnoses inclimpairment, and administration R8's quarterly MDS was totally dependent R8's care plan date required assistance 2/14/20, was R8 word daily.  On 5/17/21, at 2:35 was interviewed. FI would leave R2 lyin incontinence brief of clothes.  -at 12:44 nursing as interviewed. NA-E stated wearing just a brief could not find any country gown. NA-E stated	ess speech), and hemiplegia aralysis of one side of the simum Data Set (MDS) dated R2 was severely cognitively red assistance with dressing.  Ind 3/15/21, indicated R2 with dressing. R2's goals were ssing and he would be ed daily.  Inted on 5/19/21, indicated uded mild cognitive	21670			

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 9 of 18

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			DATE SURVEY COMPLETED	
00865			B. WING			C 1 <b>9/2021</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
FRANCIS	SCAN HEALTH CENT	FR	INESOTA AVI , MN 55802	ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21670	Continued From pa	ge 9	21670				
	interviewed. ES-C soutside facility with Wednesday, and FO On 5/19/21, at 10:2 (DON) was interviewed.	8 a.m. the director of nursing wed. The DON stated he had to three weeks that staff were					
	The administrator s	dministrator was interviewed. stated she had been aware for that staff were saying there en.					
	The Director of Nur develop, review, an procedures to ensu returned to them tir enough linen availa The Director of Nur educate all appropr procedures. The Director of Nur	THOD OF CORRECTION: rsing or designee could ad/or revise policies and are residents laundry is mely and ensure there is able for use. rsing or designee could riate staff on the policies and asing or designee could systems to ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21850	Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850			6/27/21	
	Residents shall be defined in the Vulne	om from maitreatment.  free from maltreatment as  erable Adults Protection Act.  ans conduct described in					

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 10 of 18

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00865	B. WING		05/1	9/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENT	=R	NESOTA AVI 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	section 626.5572, sintentional and non-physical pain or injuconduct intended to distress. Every resinon-therapeutic cheexcept in fully docurauthorized in writing resident's physician period of time, and protect the resident others.  This MN Requirement by: Based on interview facility failed to ensure viewed for dignity to wear. In addition, dignity was provided residents (R3) reviewed for the residents (R3) rev	subdivision 15, or the etherapeutic infliction of ary, or any persistent course of a produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as a for a specified and limited only when necessary to from self-injury or injury to ent is not met as evidenced and document review, the are 2 of 4 residents (R2, R8) were provided proper clothing, the facility failed to ensure d with toilet use for 1 of 4 ewed for toileting.  Inted on 5/19/21, indicated and uded cerebrovascular phasia (loss of the ability to ess speech), and hemiplegia aralysis of one side of the imum Data Set (MDS) dated R2 was severely cognitively a indicated he required an essing.	21850	Corrected		
		with dressing. R2's goals were ssing and he would be				

Minnesota Department of Health

STATE FORM 6899 VVZL11 If continuation sheet 11 of 18

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00865 B. WING 05/1		9/2021			
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	03/1	3/2021
	SCAN HEALTH CENT	3910 MINI	NESOTA AVI MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21850	appropriately dress On 5/17/21, at 2:35 (FM)-D was interviewed properties of the during his stay, were because he didn't halso stated she was any gowns available in tears, he was for movement. FM-D swearing only an incompairment, and add R8's Face Sheet properties of the desire of	ed daily.  In p.m. R2's family member ewed and stated that R2 was don at least one occasion aring only an incontinence brief have any clean clothes. FM-D is told the facility did not have ee. FM-D stated she found R2 ced to sit in his own bowel stated she would find R2 in bed ontinent brief because he had not the facility had no clean with the facility had no clean with the facility had no clean at the facility had no stated luded mild cognitive lult failure to thrive.  In dated 3/24/21, indicated R8 ent on staff for dressing.  In determine the facility had no clean with dressing. R8's goal was be with dressing and would be ed daily.  In gassistant (NA)-E was stated that R8 was put to bed ontinent brief because she es. The facility did not have any	21850			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00865	B. WING			C <b>19/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENTI	FR	INESOTA AVE , MN 55802	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21850	Continued From pa	ge 12	21850			
	stated the facility had including gowns.	ad been very short on linens,				
	interviewed. ES-C s	nmental service (ES)-C was stated laundry was done at an deliveries on Monday, riday.				
	(DON) was interview not dignified to leave	8 a.m. the director of nursing wed. The DON stated it was e a resident in only an he resident's preference was s or a gown.				
	diagnoses included on one side of the b	inted 5/19/21, indicated R3's spastic hemiplegia (muscles body in a constant state of left non-dominant side, and stroke).				
	was cognitively inta incontinent of urine bowel. R3's MDS in	S dated 2/15/21, indicated R3 ct, was occasionally and always continent of dicated she required be with toileting and dressing.				
	indicated R3 was using the tub/showe	a.m. a progress note pset about the difficulty in er room bathrooms, and not be bathroom because the by other residents.				
	stated she was not her shared room, he fit through the door use a commode be transfer and do not she was supposed	p.m. R3 was interviewed. R3 able to use the bathroom in er wheelchair was too wide to .R3 stated she did not want to cause they move during allow for privacy. R3 stated to use the bathrooms in the but the rooms were kept				

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NAME OF PROVIDER OR SUPPLIER  FRANCISCAN HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3910 MINNESOTA AVENUE DULUTH, MN 55802  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### STATE, ZIP CODE  ### STREET ADDRESS, CITY, STATE, ZIP CODE  ### STA				7 t. BOILBING.			
SUMMARY STATEMENT OF DEFICIENCIES   DID   PROVIDER'S PLAN OF CORRECTION (CAS) ID   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGK   PREFIX			00865	B. WING			
CAN ID PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   PREFIX TAG	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21850  Continued From page 13  locked, the floors were frequently wet, and they were not available if another resident was using the room for bathing/showering. R3 stated this caused her to have accidents, and this would make her feel bad and she would sometimes cry.  -at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring an incontinent brief with her as there were no supplies in the shower and tub rooms.  -at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms	FRANCI	SCAN HEALTH CENT	FR		ENUE		
locked, the floors were frequently wet, and they were not available if another resident was using the room for bathing/showering. R3 stated this caused her to have accidents, and this would make her feel bad and she would sometimes cry.  -at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring an incontinent brief with her as there were no supplies in the shower and tub rooms.  -at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETE
On 5/19/21, at 10:28 a.m. the DON was interviewed and stated he was aware R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine. The DON stated this was a dignity issue for R3.  -at 11:52 a.m. the administrator was interviewed. The administrator stated it was a dignity issue when someone who was continent of bladder was incontinent because they could not get to a bathroom in time.  The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to	21850	locked, the floors were not available the room for bathin caused her to have make her feel bad at 12:26 p.m. NA-1 stated R3's wheeld bathroom door. NA about 10 minutes to or tub room. NA-B would alarmed if shad an accident shincontinent brief we supplies in the short at 12:44 NA-E was witnessed R3 have episodes on "multip couldn't get into the because the door word on 5/19/21, at 10:2 interviewed and stanot always get to the intime to prevent be DON stated this was at 11:52 a.m. the administrator swhen someone whincontinent because bathroom in time.  The facility docume Compliance Relate Nursing Facilities of	vere frequently wet, and they if another resident was using g/showering. R3 stated this accidents, and this would and she would sometimes cry.  B was interviewed. NA-B hair would not fit through the aB stated it would take R3 of wheel herself to the shower stated the door was locked, it not tried to open it, and if she would need to bring an ith her as there were no wer and tub rooms.  Is interviewed. NA-E stated she abladder incontinence of the occasions because she was locked.  B a.m. the DON was atted he was aware R3 could not shower/tub room bathroom being incontinent of urine. The as a dignity issue for R3.  Indiministrator was interviewed. Stated it was a dignity issue of was continent of bladder was they could not get to a sent Best Practices For ad to Resident Dignity In Skilled reated by The American		DETICITY 1		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00865	B. WING		05/1	9/2021
	PROVIDER OR SUPPLIER SCAN HEALTH CENTI	3910 MIN	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	eat; and use speec functional commun SUGGESTED MET The Director of Nur develop, review, an procedures to ensu clothed in bed (not who are continent of incontinence. The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.	h, language, or other	21850			
21980	Maltreatment of Vu Subd. 3. Timing of reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the condividual is a vulnerable the individual is addreporter is not require maltreatment of the to admission, unless (1) the individual was another facility and	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult eysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because enitted to a facility, a mandated ired to report suspected e individual that occurred prior	21980			6/27/21

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		С	
		00865	B. WING			<i>,</i> 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FRANCI	SCAN HEALTH CENT	FR	NESOTA AVI MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte knows or has rease been made to the o (d) Nothing in thi reporter from also agency. (e) A mandated if reason to believe th 626.5572, subdivis (5), occurred must subdivision. If the time believes that a agency will determ the reported error of the criteria under s 17, paragraph (c), of facility may provide directly to the lead how the event mee 626.5572, subdivis (5). The lead age information when in the report under su  This MN Requirem by: Based on interview facility failed to report	knows or has reason to believe is a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the section may voluntarily report estates. It is section requires a report of discontinuous matter and a report has common entry point. It is section shall preclude a reporting to a law enforcement are porter who knows or has not an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or et to the common entry point or agency information explaining its the criteria under section ion 17, paragraph (c), clause not shall consider this making an initial disposition of	21980	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00865	B. WING		<b>I</b>	C <b>19/2021</b>
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FRANCI	SCAN HEALTH CENTI	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 16	21980			
	5/19/21, indicated F included unspecifie disturbance.	nosis & Allergies list printed R1 had diagnoses which d dementia without behavioral				
	3/31/21, indicated F	num Data Set (MDS) dated R1 was severely cognitively able to eat independently.				
		d 3/31/21, indicated staff was ssist and cues with meals as				
	5/12/21, indicated robserved sometime forcing R1 to drink heard RN-B say R1 couldn't drink, RN-RN-B was observed open, and forcing the was reported R1 so	to the State Agency (SA) on egistered nurse (RN)-B was in March or April of 2021, juice. The report indicated they needed to drink, and if she would make sure she drank. It holding R1's mouth forcing it ne juice down R1's throat. It creamed, choked, and lashed The reporter stated she told the incident.				
	was interviewed. RI push fluids with R1,	p.m. registered nurse (RN)-B N-B stated she has had to she puts her hand on the nd forced her to drink.				
	RN-B stated she ha	p.m. RN-B was interviewed. as had to push fluids with R1, put her hand on the back of ed her to drink.				
	reviewed/amended willful infliction of in	altreatment Prohibition 2/19/18, defined abuse as the jury, unreasonable				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00865	B. WING		<b>05/1</b>	9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FRANCI	SCAN HEALTH CENTE	-R	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21980	resulting physical had The policy directed soon as possible, be after the allegation of SUGGESTED MET. The Director of Nur develop, review, an procedures to ensure ported immediate. The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.	arm, pain, or mental anguish. staff to report immediately as ut not later than two hours is made.  THOD OF CORRECTION: sing or designee could d/or revise policies and re allegations of abuse are	21980			

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