



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 21, 2024

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: March 19, 2024

Dear Administrator:

On March 19, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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

Franciscan Health Center

March 21, 2024

Page 2

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
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 June 19, 2024 (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 September 19, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Franciscan Health Center

March 21, 2024

Page 4

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2024
--	---	--	---

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

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

F 000	<p>INITIAL COMMENTS</p> <p>On 3/15/24 and 3/19/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H52581840C (MN00101568) with deficiencies issued at F609 and F610.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 609 SS=D	<p>Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if</p>	F 609		4/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/26/2024
---	-------	--------------------------------

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.

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2024
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	<p>Continued From page 1</p> <p>the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure allegations of physical abuse were reported immediately (within two hours) to the State Agency (SA) for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's care plan dated 10/3/22, identified R1 was alert and oriented.</p> <p>R1's annual Minimum Data Set (MDS) dated 1/24/24, identified R1 had verbal and physical behaviors towards others, and needed extensive assistance with bed mobility, transfers, and toilet use.</p> <p>R1's progress note written on 3/12/24 at 10:30 p.m., by registered nurse (RN)-A indicated R1 stated staff hit his pacemaker with metal.</p>	F 609	<p>F: 609 It is Franciscan Health Center's policy to report allegations of abuse, neglect, exploitation, or mistreatment in a timely manner.</p> <p>The Administrator or Director of Nursing will oversee all sections of this plan of correction, including education, auditing, and review of those materials.</p> <ul style="list-style-type: none"> Allegations of abuse by R1 will be reported in a timely manner to the Administrator or Director of Nursing. Facility will report timely and report according to facility policy and state and federal guidelines. <p>Director of Nursing and/or designee will assess residents having potential to be affected by this practice including:</p> <ul style="list-style-type: none"> All residents within the facility could potentially be affected by this practice. 	

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2024
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	<p>Continued From page 2</p> <p>On 3/15/24 at 12:50 p.m., R1 stated on 3/12/24, RN-A came into his room, and she threw his bed remote at him hitting him in the pacemaker. R1 stated he told staff at the facility, and at the hospital what happened.</p> <p>R1's progress note on 3/15/24 at 9:59 p.m., written by RN-A indicated R1 stated the nurse threw him down the basement stairs and he hit his head.</p> <p>On 3/19/24 at 9:20 a.m., RN-B stated on 3/18/24 staff told her that last week R1 stated to the hospital that he was slapped and thrown down the stairs by staff at the facility. RN-B stated, "I was told it was being handled so I did not tell anyone. If we suspect abuse, we report it to upper management."</p> <p>On 3/19/24 at 9:32 a.m., nursing assistant (NA)-A stated on 3/13/24, R1 told her that RN-A threw something at him, and it hit his pacemaker. NA-A stated as far as she knew, it was reported as she had heard about it that morning from other staff but could not recall who. NA-A stated she talked with the nurse about it, but couldn't recall what nurse.</p> <p>On 3/19/24 at 9:41 a.m., RN-C stated on 3/15/24, she talked with R1, and he stated he did not think RN-A meant to throw his remote at him. R1's wife even came in and told us she did not think what R1 stated really happened. .</p> <p>On 3/19/24 at 9:55 a.m., the director of nursing (DON) stated she saw the progress note on 3/13/24 and asked the nurse manager to follow up with R1. The DON stated she was unsure if the manager followed up. The DON stated R1</p>	F 609	<p>Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including:</p> <ul style="list-style-type: none"> Maltreatment Reporting Guidelines policy was reviewed by the Social Services Director, Director of Nursing and Administrator regarding allegations of abuse. All nursing staff have been educated on the Maltreatment Reporting Guidelines policy by the Director of Nursing, regarding reporting immediately to the Administrator, DON, RN Manager, or Social Services director any alleged abuse at the mandatory nurse meeting held on 3/20/2024. <p>Director of Nursing and Social Services/or designee will monitor corrective actions to ensure effectiveness of these actions including:</p> <ul style="list-style-type: none"> Daily progress notes audits, which will include review of progress notes for any complaints or concerns documented to be followed up on in a timely manner will begin the week of April 1, 2024, and will continue until compliance is achieved then will become part of DON review process. Resident concern forms and grievance audits, which will include review of incident reports, concern forms and reporting checklist will be performed weekly beginning the week of April 1, 2024, and will continue until compliance is achieved then monthly thereafter. Administrator and/or designee will review documentation for potential abuse and neglect and timely reporting to state 	

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2024
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 has a history of false allegations, and when sent to the emergency room, there were no injuries, so she did not think it needed to be reported. The DON stated the facility should have reported the allegations of abuse within two hours. On 3/19/24 at 10:26 a.m., the administrator stated staff should follow the policy by reporting allegations of abuse. The facility policy Maltreatment Reporting Guidelines revised 10/18/21, directed employees are to report suspected maltreatment to a supervisor. If it is believed that the supervisor is responsible for the maltreatment the employee should then report to administrator. Any suspected maltreatment must be reported no later than 2 hours after the allegation is made.	F 609	agency. • Administrator and/or designee will audit abuse complaints to ensure that they have been reported timely to the state agency on an ongoing basis. • All audits will be brought and reviewed with quarterly QAPI committee for further recommendations. Completion date: April 15, 2024	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		4/15/24

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2024
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	<p>Continued From page 4</p> <p>appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure an allegation of potential physical abuse was thoroughly investigated and adequate resident protection provided to ensure safety for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's care plan dated 10/3/22, identified R1 was alert and oriented.</p> <p>R1's annual Minimum Data Set (MDS) dated 1/24/24, identified R1 had verbal and physical behaviors towards others and needed extensive assistance with bed mobility, transfers, and toilet use.</p> <p>R1's progress note written on 3/12/24 at 10:30 p.m., by registered nurse (RN)-A indicated R1 stated staff hit his pacemaker with metal.</p> <p>On 3/15/24 at 12:50 p.m., R1 stated on 3/12/24, RN-A came into his room, and she threw his bed remote at him hitting him in the pacemaker. R1 stated he told staff at the facility, and at the hospital what happened.</p> <p>R1's progress note on 3/15/24 at 9:59 p.m., written by RN-A indicated R1 stated the nurse threw him down the basement stairs and he hit his head.</p> <p>On 3/19/24 at 9:55 a.m., the director of nursing (DON) stated she saw the progress note on 3/13/24 and asked the nurse manager to follow</p>	F 610	<p>F 610 It is Franciscan Health Center's policy to Investigate/Prevent/Correct Alleged Violation</p> <p>Director of Nursing and/or designee will implement corrective action for resident R1 affected by this practice by:</p> <ul style="list-style-type: none"> • Allegations of abuse by R1 will be investigated thoroughly. • Steps will be taken to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. <p>Director of Nursing and/or designee will assess residents having potential to be affected by this practice including:</p> <ul style="list-style-type: none"> • All residents within the facility could potentially be affected by this practice. <p>Director of Nursing and/or designee will implement measures to ensure that this practice does not recur including:</p> <ul style="list-style-type: none"> • All allegations of abuse will be reviewed timely with the DON and/or designee and investigated and reported according to facility policy and federal guidelines. • RN-A was educated on timely reporting of alleged abuse on 3/20/2024 by the DON. • All nursing staff were educated on timely reporting of alleged abuse per the Maltreatment Reporting Guidelines policy on 3/20/2024 during the mandatory nursing meeting. • On 3/20/2024, the Social Services 	

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

PRINTED: 04/11/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/19/2024
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	<p>Continued From page 5</p> <p>up with R1. The DON stated she was unsure if the manager followed up. The DON stated R1 has a history of false allegations, and when sent to the emergency room, there were no injuries. The DON stated the facility did not complete an investigation.</p> <p>On 3/19/24 at 10:26 a.m., the administrator stated should follow the policy by investigating allegations of abuse. The administrator verified an investigation was not completed for this allegation.</p> <p>The facility policy Maltreatment Investigation & Reporting revised 10/18/21 directed our care center will investigate all incidents and allegations of maltreatment.</p>	F 610	<p>Director was educated by the Administrator regarding proper alleged abuse investigation and follow through, including timely reporting of alleged abuse, conducting record reviews, interviews of other residents and staff, etc.</p> <ul style="list-style-type: none"> All residents within the facility could potentially be affected by this practice. <p>Director of Nursing and/or designee will monitor corrective actions to ensure effectiveness of these actions including:</p> <ul style="list-style-type: none"> Daily progress notes audits, which will include review of progress notes for any complaints or concerns documented to be followed up on in a timely manner will begin the week of April 1, 2024, and will continue until compliance is achieved then will become part of DON review process. Resident concern forms and grievance audits, which will include review of incident reports, concern forms and reporting checklist will be performed weekly beginning the week of April 1, 2024, and will continue until compliance is achieved then monthly thereafter. All audits will be brought and reviewed with quarterly QAPI committee meeting for further recommendations. <p>Completion date: April 15, 2024</p>	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 21, 2024

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: Event ID: S2UV11

Dear Administrator:

The above facility survey was completed on March 19, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00865	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2024
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request 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.</p> <p>INITIAL COMMENTS: On 3/15/24 and 3/19/24, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed:</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/26/24
---	-------	------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00865	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/19/2024
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	Continued From page 1 H52581840C (MN00101568) The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	2 000		
-------	--	-------	--	--