DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: July 13, 2022

Dear Administrator:

On August 18, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: 04GN12

Dear Administrator:

On August 18, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 21, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: July 13, 2022

Dear Administrator:

On July 13, 2022, 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"and/or an E tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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 October 13, 2022 (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 January 13, 2023 (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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 07/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/11/22 through 7/13/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H52583149C (MN84853) was found to be SUBSTANTIATED: with a a deficiency was cited at F604. As a result of the investigation a related deficiency was cited at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		8/15/22

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

Electronically Signed | 07/26/2022

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

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F 604	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure physical restraints were not implemented for 1 of 3 resident (R1) reviewed for physical restraint. Findings included: R1's significant change Minimum Data Set (MDS) dated 6/13/22 identified R1 had severe cognitive impairment with no behavior issues. R1 required extensive assistance from staff for personal hygiene. The MDS included diagnoses of non-Alzheimer's dementia and anxiety. R1's care plan reviewed 5/25/22, identified R1 could become combative with cares.	F 604	F 604 Right to be free from Physical Restraint The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • R1-abuse allegation was investigated and a report filed on 7/6/2022 to the State Agency (SA), Tracking ID 348245. • All residents within the facility could potentially be impacted by this practice. • On 7/6/2022 RN-A and NA-A were suspended upon completion of investigation. • On 7/6/2022 RN Nurse Manager DM completed a physical assessment and	

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F 604	Continued From page 2 Interventions included to explain and allow time to respond and if becomes combative with care take a step back and reproach, reminisce about family, and allow resident to call daughter. During an interview on 7/12/22, at 11:11 a.m. nursing assistant (NA)-A stated right before supper on 7/5/22, R1 removed her dentures and registered nurse (RN)-A was trying to get them back in her mouth. NA-A took R1's dentures and placed her hand behind R1's neck so R1 could not pull her head back or turn her head. R1 was initially pulling away when trying to put the dentures in. When NA-A was trying to get R1's dentures in. RN-A was holding R1's hands down but was unsure of the position. This continued for about a minute before NA-A and RN-A stopped trying to place the dentures and let her go back to the dining room. During an interview on 7/12/22, at 1:44 p.m. NA-B stated during supper on 7/5/22, they heard R1 making noise that sounded like a couple of yelps, scream, and heard "no" once or twice that lasted about 30 seconds; however, could only see RN-A standing in front of R1 and NA-A holding R1's dentures in front of R1. During an interview on 7/12/22, at 2:06 p.m. NA-D stated on 7/5/22, R1 took her bottom denture out and RN-A brought R1 to the nurses' station. RN-A was trying to talk R1 into putting her dentures back in. R1 was telling RN-A no and was turning their head away. NA-A came over to assist RN-A. NA-A took the residents dentures and placed her hand behind the resident's neck to keep her head still and not pull away and was placing dentures right by her mouth. During this time RN-A had R1's hands pinned down in her	F 604	found resident to be at baseline with no bruising or redness noted on wrist or lower arms. • On 7/6/2022 Social Services Director interviewed R1 and found no emotional impact or recall of event. R1 found to be at cognitive baseline. • On 7/6/2022 Social Service Director performed house wide interviews with all residents' regarding potential abuse, neglect situations, and if they had ever been forced to perform something that they did not want to do. No concerns noted from those interviews. • On 7/8/2022 RN-A was terminated and NA-A chose not to return to work following her suspension. • The IDT team reviewed R1 care plan and on 7/11/2022 care conference with family completed to identify additional interventions to assistant in R1's care. IDT team will communicate with family on effectiveness of interventions. • On 7/12/2022 Social Services Director and Administrator started full-house wide education to all staff and newly hired staff on the Maltreatment Prohibition Policy (Definition of Abuse and reporting timeframe) and Protecting Victims of Maltreatment Policy, Understanding the resident right to refuse care and what to do if that occurs, improper use of restraints with residents (some examples of restraints were given) and the facility (FHC) is a restraint free facility. Techniques shared to assist in providing care to the Cognitively Impaired residents. • Social Services Director/designee will be auditing three (3) random residents	

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F 604	Continued From page 3 wheelchair so she could not move her hands. During an interview on 7/12/22, at 2:58 p.m. RN-A stated R1 removed her dentures before supper on 7/5/22. RN-A attempted to talk R1 into putting the dentures back in and was unsuccessful. RN-A went and helped another resident and came back to R1 and started again trying to put the dentures in again. NA-A offered to help and took the dentures and started talking with R1. R1 was being combative, and RN-A stated she held R1's hands to occupy them and R1 was resistive to having her hands held. RN-A stated she continued to hold R1's hands until the staff stopped attempting to place the dentures in her mouth and then RN-A released R1's hands. NA-A and RN-A were attempting to get R1 to get her dentures for about 3 minutes before they stopped trying. During an interview on 7/13/22, at 12:58 p.m. the administrator stated all residents were to be free from abuse and restraint. The administrator would have expected RN-A and NA-A to allow R1 to refuse to have her dentures in. Instead, they restrained the resident and tried to force her to put her dentures in, and that action was unacceptable. The facility's "VA Physical Restraint Policy" dated 10/3/16, identified each vulnerable adult (VA) had the right to be free from any physical restraint. A physical restraint was defined as any manual or physical method where the VA cannot easily remove and the restricts freedom of movement or normal access to his/her body.	F 604	each week X 4 weeks and then three (3) resident every other week x 4 weeks, then three (3) residents monthly x2 months to identify if they have seen or were forced to perform something that they did not want to do or felt that they were restrained. • Social Services Director/designee will be auditing three (3) staff members each week X 4 weeks and then three (3) resident every other week x 4 weeks, then three (3) residents monthly x2 months to identify if they have observed the use of restraint with the residents. • Director of Nursing/designee will be auditing three (3) random residents each week x4 weeks, then three (3) resident every other week x 4 weeks, then three (3) residents monthly x2 months to watch cares and to identify if any restraints are used and to identify if preferences are being met. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		8/15/22

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F 609	Continued From page 4 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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 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. §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: Based on interview and document review, the facility failed to timely identify and report an allegation of potential abuse for 1 of 3 residents (R1) who was reviewed for abuse. Findings included: The facility incident report submitted to the State	F 609	F 609 Reporting of Alleged Violations The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • R1-abuse allegation was investigated and a report filed on 7/6/2022 to the State	

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F 609	Continued From page 5 Agency (SA) on 7/6/22, at 10:19 a.m. identified the alleged incident of abuse occurred on 7/5/22, at 4:45 p.m. The allegation involved registered nurse (RN)-A and nursing assistant (NA)-A when they were attempting to place R1's dentures in her mouth. The allegation identified R1's hands were being held down and R1 stated "Stop you are hurting me". During an interview on 7/12/22, at 2:06 p.m. nursing assistant (NA)-D stated she was assisting a resident with supper on 7/5/22, and observed the incident. NA-D explained what she witnessed to her mentor NA-C. NA-C informed licensed practical nurse (LPN)-A on the unit of the incident and filled out a concern form. Staff were educated if they ever saw an incident of potential abuse, they would need to report it to the nurse on duty, the administrator, or the director of nursing (DON). During an interview on 7/12/22, at 2:41 p.m. NA-C reported the concern witnessed by NA-A to LPN-A and filled out a concern form. NA-C stated she was taught if they witnessed an incident of concern or abuse, they were to report it to the nurse on duty if it was not during normal business hours. During an interview on 7/13/22, at 12:44 p.m. LPN-A stated she was working the night of the incident and about 6:00 p.m. NA-C told her of the incident and was filling out a concern form. LPN-A stated she was not sure of who to contact or if anything had to be filled out. LPN-A did not see any concerns with R1 when the incident was reported and felt the concern form would be sufficient. Looking back, the administrator should have been contacted right away, but wasn't.	F 609	Agency (SA), Tracking ID 348245. • All residents within the facility could potentially be impacted by this practice. • All allegations of abuse will be reported timely to the Administrator. Facility will report timely and report according to facility policy and state and federal guidelines. • On 7/6/2022 Social Services Director performed house wide interviews all residents regarding potential abuse situations and whether timely reporting needed, with no VA or concerns identified that needed reporting to SA. • On 7/12/2022 Social Services Director educated management staff on Maltreatment Prohibition Policy (Definition of Abuse and reporting timeframe) and Protecting Victims of Maltreatment Policy. Emphasis focused on the timely reporting of suspected abuse. • On 7/12/2022 Social Services Director and Administrator started full-house wide education to all staff on the Maltreatment Prohibition Policy (Definition of Abuse and reporting timeframe) and Protecting Victims of Maltreatment Policy. Emphasis focused on the timely reporting of suspected abuse. • On 7/13/2022 Social Services Director educated NAR JGA and NAR SO on timely reporting of all alleged violations. • Audits will be completed with all department heads reviewing employee/resident concerns with Administrator. Administrator will review all documentation for potential abuse and neglect with timely reporting to SA for the next 90 days.	

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F 609	Continued From page 6 During an interview on 7/13/22, at 12:58 p.m. the administrator identified the incident should have been reported to the DON or the administrator as soon a time as the resident was safe and reported no more than two hours after the incident. The incident should have been reported immediately. The administrator was informed of the incident the morning of 7/6/22. The facility's Maltreatment and Reporting Guidelines dated 10/18/21, identified the care center must report to the SA any suspected maltreatment (including alleged violations involving abuse, neglect, or maltreatment) immediately, but not later than two hours after the allegation was made.	F 609	• Random audits will be performed by Social Services Director weekly interviewing three (3) random residents/staff each week for potential abuse with timely reporting until compliance achieved. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations. Completion date: 08/15/2022.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: 04GN11

Dear Administrator:

The above facility was surveyed on July 11, 2022 through July 13, 2022 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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:

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

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 07/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 7/11/22, through 7/13/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The complaint H52583149C (MN84853) was found to be SUBSTANTIATED, with a licensing order issued at MN Rule 4658.0300 Subp. 2. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure physical restraints were not implemented for 1 of 3 resident (R1) reviewed for physical restraint. Findings included: R1's significant change Minimum Data Set (MDS) dated 6/13/22 identified R1 had severe cognitive impairment with no behavior issues. R1 required extensive assistance from staff for personal hygiene. The MDS included diagnoses of non-Alzheimer's dementia and anxiety. R1's care plan reviewed 5/25/22, identified R1 could become combative with cares. Interventions included to explain and allow time to respond and if becomes combative with care take a step back and reproach, reminisce about	2 510	Corrected	8/15/22

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2 510	Continued From page 3 family, and allow resident to call daughter. During an interview on 7/12/22, at 11:11 a.m. nursing assistant (NA)-A stated right before supper on 7/5/22, R1 removed her dentures and registered nurse (RN)-A was trying to get them back in her mouth. NA-A took R1's dentures and placed her hand behind R1's neck so R1 could not pull her head back or turn her head. R1 was initially pulling away when trying to put the dentures in. When NA-A was trying to get R1's dentures in. RN-A was holding R1's hands down but was unsure of the position. This continued for about a minute before NA-A and RN-A stopped trying to place the dentures and let her go back to the dining room. During an interview on 7/12/22, at 1:44 p.m. NA-B stated during supper on 7/5/22, they heard R1 making noise that sounded like a couple of yelps, scream, and heard "no" once or twice that lasted about 30 seconds; however, could only see RN-A standing in front of R1 and NA-A holding R1's dentures in front of R1. During an interview on 7/12/22, at 2:06 p.m. NA-D stated on 7/5/22, R1 took her bottom denture out and RN-A brought R1 to the nurses' station. RN-A was trying to talk R1 into putting her dentures back in. R1 was telling RN-A no and was turning their head away. NA-A came over to assist RN-A. NA-A took the residents dentures and placed her hand behind the resident's neck to keep her head still and not pull away and was placing dentures right by her mouth. During this time RN-A had R1's hands pinned down in her wheelchair so she could not move her hands. During an interview on 7/12/22, at 2:58 p.m. RN-A stated R1 removed her dentures before supper	2 510		

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2 510	Continued From page 4 on 7/5/22. RN-A attempted to talk R1 into putting the dentures back in and was unsuccessful. RN-A went and helped another resident and came back to R1 and started again trying to put the dentures in again. NA-A offered to help and took the dentures and started talking with R1. R1 was being combative, and RN-A stated she held R1's hands to occupy them and R1 was resistive to having her hands held. RN-A stated she continued to hold R1's hands until the staff stopped attempting to place the dentures in her mouth and then RN-A released R1's hands. NA-A and RN-A were attempting to get R1 to get her dentures for about 3 minutes before they stopped trying. During an interview on 7/13/22, at 12:58 p.m. the administrator stated all residents were to be free from abuse and restraint. The administrator would have expected RN-A and NA-A to allow R1 to refuse to have her dentures in. Instead, they restrained the resident and tried to force her to put her dentures in, and that action was unacceptable. The facility's "VA Physical Restraint Policy" dated 10/3/16, identified each vulnerable adult (VA) had the right to be free from any physical restraint. A physical restraint was defined as any manual or physical method where the VA cannot easily remove and the restricts freedom of movement or normal access to his/her body. SUGGESTED METHOD OF CORRECTION: The administrator or designee could observe cares and interactions to ensure residents that refuse cares are not improperly restrained. All staff could be educated on behavioral techniques to ensure residents are not restrained. Audits could be conducted of resident care to ensure	2 510		

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2 510	Continued From page 5 compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 510		