



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
September 10, 2024

Administrator  
Franciscan Health Center  
3910 Minnesota Avenue  
Duluth, MN 55802

RE: CCN: 245258  
Cycle Start Date: August 9, 2024

Dear Administrator:

On September 10, 2024, 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,

A handwritten signature in blue ink that reads 'Sarah Lane'.

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



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
August 15, 2024

Administrator  
Franciscan Health Center  
3910 Minnesota Avenue  
Duluth, MN 55802

RE: CCN: 245258  
Cycle Start Date: August 9, 2024

Dear Administrator:

On August 9, 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 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](mailto: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 November 9, 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 February 9, 2025 (six months after

Franciscan Health Center

August 15, 2024

Page 3

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](https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm)

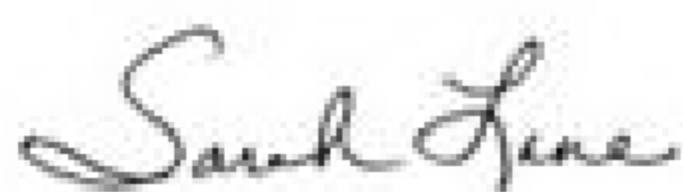
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2024</b>
--	---	--	---

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

(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 8/8/24 through 8/9/24, 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: H52586578C (MN00105542) with deficiencies issued at F600, F609, and F943. H52586686C (MN00105488)</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 600 SS=D	<p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation 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.</p>	F 600		9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  08/23/2024
--	-------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 600	<p>Continued From page 1</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to protect a resident's right to be free from sexual abuse by staff for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Face Sheet undated, identified R1 had schizoaffective disorder, autistic disorder, bipolar disorder, intellectual disabilities, Alzheimer's disease, dementia, and schizophrenia.</p> <p>An Annual Notice of Right to Petition for Termination or Modification of Guardianship or Other Relief dated 6/3/24 indicated R1 had a court appointed guardian due to his inability to be his own decision maker.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/29/24, identified R1 had severe cognitive impairment, delusions, and needed extensive assistance with all cares, and supervision for eating.</p> <p>R1's care plan dated 2/23/24, indicated R1 makes inappropriate sexual comments and may touch others inappropriately. Interventions included cares in pairs, redirect R1, remove R1 from the situation, and observe R1 during meals and activities.</p>	F 600	<p>F: 600 It is Franciscan Health Center's policy to keep residents free from abuse and neglect.</p> <p>The Administrator or Director of Nursing will implement corrective action for resident R1 affected by this practice by:</p> <ul style="list-style-type: none"> <li>•R1 abuse allegation was investigated, and a report filed on 08/05/2024 to the State Agency.</li> <li>•R1 has some cognitive impairment and initiated inappropriate contact with a cognitively impaired employee (H)-A. Employee (H)-A is developmentally disabled. She left employment on 08/05/2024 and will not be returning.</li> </ul> <p>The Administrator or Director of Nursing will assess residents having the potential to be affected by this practice including:</p> <ul style="list-style-type: none"> <li>•All residents have the potential to be affected by this deficient practice.</li> </ul> <p>The Administrator or Director of Nursing will implement measures to ensure that this practice does not recur including:</p> <ul style="list-style-type: none"> <li>•Maltreatment Prohibition and Protecting Victims from Abuse policies were reviewed by the Administrator, Social Service Director, and the Director of Nursing</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 600	<p>Continued From page 2</p> <p>On 8/6/24 at 11:57 a.m., a progress note by registered nurse (RN)-A indicated R1 stated to RN-A that he had a girlfriend from housekeeping. R1 stated they loved each other, and she came in his room, and they touched each other.</p> <p>On 8/8/24 at 1:50 p.m., R1 stated two to three days ago he met housekeeper (H)-A, and she came into his room. He touched her breast and vagina with his hands, and they kissed. He knew he was not supposed to do anything with workers at the facility, but he loved H-A. He wanted this to happen as H-A was going to be his wife.</p> <p>On 8/8/24 at 3:03 p.m., RN-A stated on 8/6/24, R1 came to her and told her that he had a girlfriend, they loved each other. H-A had come into his room, and they touched each other. She didn't tell anyone about the incident, but documented it in R1's medical record as she knew it needed to be investigated. She was concerned if the interaction was consensual.</p> <p>On 8/9/24 at 8:38 a.m., H-A stated on 8/5/24 in the afternoon, she was in the dining room folding napkins and R1 asked her if she would be his girlfriend, and if she would go to his room. She told R1 she would be his girlfriend, and she went to R1's room. R1 touched her breasts and vagina with his hands. R1 asked her for a kiss, so she kissed him on the cheek. R1 asked for a kiss on the lips, so she kissed him on the lips. He told her he loved her, and they left the room and went to the dining room. R1 drank coffee and she left the facility as her shift was over. She was not aware she was not supposed to have relations with residents until her after the encounter with R1.</p>	F 600	<p>regarding any maltreatment.</p> <ul style="list-style-type: none"> <li>•All staff will be re-educated on the Maltreatment policies by 08/30/2024.</li> </ul> <p>The Administrator or Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:</p> <ul style="list-style-type: none"> <li>•Daily audits by review of progress notes for any complaints or concerns documented to be followed up on in a timely manner will be completed by the Director of Nursing and/or designee beginning the week of August 26, until compliance is achieved.</li> <li>•Weekly audits of incident reports, resident concern forms and grievances will be completed by the Social Service Director and/or designee beginning the week of Augst 26 until compliance is achieved.</li> <li>•The Administrator and /or designee will review documentation for potential abuse and neglect and timely reporting to state agency.</li> <li>•Audit results will be brought to the QAPI committee quarterly for review and further recommendation.</li> </ul> <p>Completion Date: 09/06/2024</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 600	Continued From page 3  On 8/9/24 at 9:37 a.m., occupational therapy assistant (OTA)-A stated after testing, she did not think R1 was cognitively intact enough to make his own choice of being in a relationship. OTA-A stated R1 was spontaneous and inappropriate at times, but did not understand the ramifications or consequences of his actions.  The facility policy Protecting Victims of Maltreatment revised 10/18/21, directed the care center would protect a vulnerable adult from maltreatment.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(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.	F 609		9/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 4</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 sexual 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 Face Sheet undated, identified R1 had schizoaffective disorder, autistic disorder, bipolar disorder, intellectual disabilities, Alzheimer's disease, dementia, and schizophrenia.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/29/24, identified R1 had severe cognitive impairment, delusions, and needed extensive assistance with all cares, and supervision for eating.</p> <p>On 8/6/24 at 11:57 a.m., a progress note by registered nurse (RN)-A indicated R1 stated to RN-A that he had a girlfriend from housekeeping. R1 stated they loved each other, and she came in his room, and they touched each other.</p> <p>On 8/8/24 at 1:50 p.m., R1 stated two to three days ago he met housekeeper (H)-A, and she came into his room. He touched her breast and vagina with his hands, and they kissed. He knew</p>	F 609	<p>F: 609 It is Franciscan Health Center's policy to report alleged violations of abuse, neglect, or mistreatment in a timely manner.</p> <p>The Administrator or Director of Nursing will implement corrective action for resident R1 affected by this practice by:</p> <ul style="list-style-type: none"> <li>•R1 abuse allegation was investigated, and a report filed on 08/05/2024 to the State Agency.</li> </ul> <p>The Administrator or Director of Nursing will assess residents having the potential to be affected by this practice including:</p> <ul style="list-style-type: none"> <li>•All residents have the potential to be affected by this deficient practice.</li> </ul> <p>The Administrator or Director of Nursing will implement measures to ensure that this practice does not recur including:</p> <ul style="list-style-type: none"> <li>•Maltreatment Prohibition and Protecting Victims from Abuse policies were reviewed by the Administrator, Social Service Director, and the Director of Nursing regarding any maltreatment.</li> <li>•All staff will be re-educated on the Maltreatment policies by 08/30/2024.</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 5</p> <p>he was not supposed to do anything with workers at the facility, but he loved H-A. He wanted this to happen as H-A was going to be his wife.</p> <p>On 8/8/24 at 3:03 p.m., RN-A stated on 8/6/24, R1 came to her and told her that he had a girlfriend, they loved each other. H-A had come into his room, and they touched each other. She didn't tell anyone about the incident, but documented it in R1's medical record as she knew it needed to be investigated. RN-A did not say why she did not report the incident.</p> <p>On 8/9/24 at 8:38 a.m., H-A stated on 8/5/24 in the afternoon, she was in the dining room folding napkins and R1 asked her if she would be his girlfriend, and if she would go to his room. She told R1 she would be his girlfriend, and she went to R1's room. R1 touched her breasts and vagina with his hands. R1 asked her for a kiss, so she kissed him on the cheek. R1 asked for a kiss on the lips, so she kissed him on the lips. He told her he loved her, and they left the room and went to the dining room. R1 drank coffee, and she left the facility as her shift was over. She was not aware she was not supposed to have relations with residents until her after the encounter with R1.</p> <p>On 8/9/24 at 11:58 a.m., RN-B stated it was expected staff report suspected or alleged abuse within two hours. If a resident told a staff member that they were in love with a staff and they touched each other, staff should report it right away.</p> <p>On 8/9/24 at 12:11 p.m., the director of nursing (DON) stated the expectation of staff is to report any alleged or potential abuse within two hours.</p>	F 609	<p>The Administrator or Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:</p> <ul style="list-style-type: none"> <li>•Daily audits by review of progress notes for any complaints or concerns documented to be followed up on in a timely manner will be completed by the Director of Nursing and/or designee beginning the week of August 26, until compliance is achieved.</li> <li>•Weekly audits of incident reports, resident concern forms and grievances will be completed by the Social Service Director and/or designee beginning the week of August 26, until compliance is achieved.</li> <li>•The Administrator and /or designee will review documentation for potential abuse and neglect and timely reporting to state agency.</li> <li>•Audit results will be brought to the QAPI committee quarterly for review and further recommendation.</li> </ul> <p>Completion Date: 09/06/2024</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 6 She would consider the progress note written by RN-A on 8/6/24 potential abuse.  On 8/9/24 at 12:33 p.m., the administrator stated staff should follow the policy and report abuse timely.  The facility policy Maltreatment Reporting Guidelines revised 10/18/21, directed employees 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		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)  §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.  §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property  §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure required abuse, neglect,	F 943	F: 943 It is Franciscan Health Center's policy to ensure all staff have the required	9/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE DULUTH, MN 55802</b>		
(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 943	<p>Continued From page 7</p> <p>and exploitation training was completed for 1 of 3 staff (housekeeper [H]-A) whose personnel records were reviewed.</p> <p>Findings include:</p> <p>On 8/9/24 at 8:38 a.m., H-A stated she did not recall the last time she had abuse, neglect, and exploitation training.</p> <p>Review of personnel files on 8/9/24, indicated H-A had not had training on abuse, neglect, and exploitation since 6/7/21.</p> <p>On 8/9/24 at 12:11 p.m., the director of nursing (DON) stated every staff should have abuse training upon hire, annually, and as events occur.</p> <p>On 8/9/24 at 12:33 p.m., the administrator stated H-A has had no education on abuse, neglect, and exploitation since 2021. Staff should have this education upon hire and annually.</p> <p>A facility policy titled Maltreatment Prohibition policy reviewed 10/18/21 directed employees would be trained on Maltreatment Prohibition polices and procedures during the orientation process, and on an annual basis.</p>	F 943	<p>training at least annually.</p> <p>The Administrator or Director of Nursing will implement corrective action for resident R1 affected by this practice by:</p> <ul style="list-style-type: none"> <li>•Employee (H)-A left employment on 08/05/2024 and will not be returning.</li> </ul> <p>The Administrator or Director of Nursing will assess residents having the potential to be affected by this practice including:</p> <ul style="list-style-type: none"> <li>•All residents have the potential to be affected by deficient practice.</li> </ul> <p>The Administrator or Director of Nursing will implement measures to ensure that this practice does not recur including:</p> <ul style="list-style-type: none"> <li>•An audit of all staff was completed to ensure they had completed their hire or annual Vulnerable Adult Training. Any staff that did not have it completed will complete it by 08/23/2024 or be removed from the schedule.</li> </ul> <p>The Administrator or Director of Nursing will monitor corrective actions to ensure the effectiveness of these actions including:</p> <ul style="list-style-type: none"> <li>•Weekly new hire and monthly anniversaries will be audited to ensure staff have completed their new hire or annual training by Human Resources beginning the week of August 26, until compliance is achieved.</li> <li>•Audit results will be brought to the QAPI committee quarterly for review and further recommendation.</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245258</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/09/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3910 MINNESOTA AVENUE</b> <b>DULUTH, MN 55802</b>		
(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 943	Continued From page 8	F 943	Completion Date: 09/06/2024	



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

August 15, 2024

Administrator  
Franciscan Health Center  
3910 Minnesota Avenue  
Duluth, MN 55802

Re: Event ID: R5Y111

Dear Administrator:

The above facility survey was completed on August 9, 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 cursive script that reads 'Sarah Lane'.

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