

Electronically Delivered December 6, 2023

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: October 5, 2023

Dear Administrator:

On November 22, 2023, the Minnesota Departments of Health and Public Safety, 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,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered

December 6, 2023

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

Re: Reinspection Results

Event ID: 57E212

Dear Administrator:

On November 22, 2023 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 October 5, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumalu Fiske Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered October 17, 2023

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

RE: CCN: 245258

Cycle Start Date: October 5, 2023

Dear Administrator:

On October 5, 2023, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082

Email: Alex.Warren@state.mn.us

Mobile: 651-279-5375 Office: 218-302-6186

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 January 5, 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 April 5, 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.

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:

Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kumala Fiske-Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 10/27/2023 FORM APPROVED OMB NO. 0938-0391

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245258	B. WING			C 10/05/2023		
	PROVIDER OR SUPPLIER			391	REET ADDRESS, CITY, STATE, ZIP CODE 10 MINNESOTA AVENUE 1LUTH, MN 55802	10/03/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION		
E 000	Initial Comments		E 0	00				
	with Appendix Z, E Requirements, §48	5/23, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The pliance.						
F 000	signature is not rec page of the CMS-2 correction is require acknowledge recei	led in ePOC and therefore a puired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility pt of the electronic documents.	F 0	00				
	survey was conduction was a mas NOT compliant	5/23, a standard recertification ted at your facility. A complaint also conducted. Your facility nce with the requirements of art B, Requirements for Long s.						
	The following complete deficiencies cited. H52586007C (MN H52586008C (MN H52586006C (MN H52586006C (MN H52586010C (MN H52586010C (MN	90854) 93869) 93868) 93871)						
	as your allegation of the asyour allegation of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 aic submission of the POC will tion of compliance.						
_ABORATOR`	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE	(X6) DATE		

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

Electronically Signed

10/26/2023

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MUL [*] A. BUILDI) CON) DATE SURVEY COMPLETED		
		245258	B. WING			C /05/2023
	PROVIDER OR SUPPLIER	ER				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 000	Continued From pa	ge 1	F 0	00		
	onsite revisit of you	acceptable electronic POC, an refacility may be conducted to compliance with the en attained.				
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1		F 5	61		11/20/23
	promote and facilitathrough support of not limited to the right (1) through (11) of the activities, schedules waking times), heal care services considerations.	e right to and the facility must ate resident self-determination resident choice, including but this specified in paragraphs (f) this section. esident has a right to choose including sleeping and the care and providers of health stent with his or her interests, plan of care and other				
	choices about aspe	esident has a right to make ects of his or her life in the ificant to the resident.				
	with members of th	esident has a right to interact e community and participate in s both inside and outside the				
	participate in other religious, and comminterfere with the right facility.	esident has a right to activities, including social, nunity activities that do not ghts of other residents in the				
	by:	Vand doormant review the		E. EGA IA: a Emana: a a a a la a	1th Cantan's	
	pased on interview	and document review, the		F: 561 It is Franciscan Hea	aith Centers	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C 05/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3910 MINNESOTA AVENUE DULUTH, MN 55802	<u> </u>		
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F 561	Continued From pa	age 2	F 5	61			
	facility failed to hon	or individual preferences for ing for 1 of 4 residents (R7)		policy to provide residents the choices in the care routine.	right to		
	Findings include:			Director of Nursing and/or design implement corrective action for R7 affected by this practice by	or resident y:		
		mum Data Set (MDS) dated 7 was cognitively intact.		 R7 will have brief checked changed at 0500 and Q2-3H F R7 care plan was reviewed 	PRN.		
	,	esheet identified R7 had and a		2023 and currently reflects pre	eference.		
	history of urinary tr	•		Director of Nursing and/or des	•		
	•	ed 8/17/23, directed staff to R7's brief at 5:00 a.m. R7 had tract infections.		 be affected by this practice inc All residents with specific outlined in the care plan have 	preferences the potential		
		on 10/2/23 at 1:27 p.m., R7 edly told staff they wanted staff		to be affected by the same de practice.	licient		
	to wake them up at getting done. R7 sl managers. If the ni 5:00 a.m. R7 usual	s 5:00 a.m., but it was not nared this request with ght staff didn't get R7 up at ly had to wait until around 7:00 nce to the bathroom.		Director of Nursing and/or desimplement measures to ensur practice does not recur include. • Education provided to state honoring resident preferences centered policy reviewed with	re that this ing: ff on s. Person		
	reported they had v	on 10/4/23 at 7:37 a.m., R7 woken up around 6:00 a.m. staff to come in. R7 did not		given to direct care staff at CN held 10-12-2023.	JA meeting		
	indicated no one w 5:00 a.m.	ey got up on 10/3/23, but oke R7 to use the bathroom at		Director of Nursing and/or design monitor corrective actions to effectiveness of these actions Random audits identifying 	ensure the including: personal		
	stated nobody wok had to call for staff up. R7 explained th	on 10/5/23 at 1:34 a.m., R7 e them at 5:00 a.m. and R7 assistance when they woke ney wanted staff to get them up se they didn't want to have an		choices will be completed by I Nursing/designee 5 residents/ week, 3 residents/week x 2 weeks one resident weekly x 2 weeks monthly thereafter beginning to	/week x 1 eeks, then s, and then		
	incontinence episo	de. They were not concerned continence but were afraid of		November 6, 2023. • Audit results will be broug			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245258	B. WING _			C 05/2023
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F 561	getting a UTI from k waited their turn for	being in a wet brief while they help.	F 56	QAPI committee quarterly for revi further recommendation.		
	registered nurse (Respectation that states 5:00 a.m. each more preference. R7's care	on 10/5/23 at 11:54 a.m., N)-B stated it was her ff would be getting R7 up at ning because that was R7's re plan was specifically a 5:00 a.m. wake time as that e.		Completion Date: November 20, 2	2023	
	director of nursing (planned for a residenthen they expected morning at 5:00 a.m.	on 10/5/23 at 2:07 p.m., the DON) stated if it was care ent to be woke up at 5:00 a.m., staff would be going in each n. to see if the resident wanted est to be woken at 5:00 a.m.				
	dated 3/7/22, indicated develop an individual respected and identification when determining dated are resident choices as was no risk associated.	cords of Personal Funds	F 56	8		11/20/23
	(A) The facility must system that assures separate accounting accepted accounting personal funds entry resident's behalf.	ccounting and Records. It establish and maintain a Is a full and complete and Ig, according to generally Ig principles, of each resident's Instead to the facility on the Ist preclude any commingling				

lacksquare		E SURVEY PLETED			
	245258	B. WING			C 05/2023
			STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802	CODE	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
of resident funds we funds of any perso (C) The individual fit available to the resistatements and up This REQUIREME by: Based on interview facility failed to ensaccounts received residents (R7) revished the potential to discharged resident managed by the facility for their personal facility facility for their personal facility fac	with facility funds or with the nother than another resident. nancial record must be ident through quarterly on request. NT is not met as evidenced and document review the sure residents with trust quarterly statements for 1 of 1 ewed for resident funds. This is affect 58 current and its who had personal accounts cility. mum Data Set (MDS) dated 7 was cognitively intact. y on 10/2/23 at 1:12 p.m., R7 eceived statements from the sonal trust account. y on 10/4/23 at 3:13 p.m. the rmed resident trust account of sent out since his start date ity had 58 residents with a trust lity. Residents and/or their uld receive quarterly trust is. onthly Summary, dated 10/4/23, re 58 residents with current he facility; however, not all in the facility were identified to		F: 568 It is Franciscan Heapolicy to provide residents/statements of their trust fur least quarterly. Administrator and/or design implement corrective action R7 affected by this practice R7 was given a trust stato/23/2023. Administrator and/or design residents having the potent affected by this practice ince All residents who have accounts have the potentia by deficient practice. All residents/families w accounts had their trust fundelivered or mailed on 10/2 Administrator and/or design implement measures to enspractice does not recur incle The Resident Trust Fur policy was reviewed. The administrator was policy regarding providing to statements at least quarterly	families nd accounts at nee will n for resident by: natement on nee will assess ial to be cluding: trust fund I to be affected ith trust fund nd statements 23/2023. nee will sure that this luding: nd Account trained on the rust fund ly.	
Trust account polic	es were requested but not				
	Continued From particles of the president funds with funds of any perso (C) The individual finavailable to the resistatements and up This REQUIREME by: Based on interview facility failed to ensure accounts received residents (R7) revishad the potential to discharged resident managed by the facility for their personance of 1/3/23, indicated R. During an interview stated they never reacility for their personance of 1/3/23. The facility for the f	Continued From page 4 of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents with trust accounts received quarterly statements for 1 of 1 residents (R7) reviewed for resident funds. This had the potential to affect 58 current and discharged residents who had personal accounts managed by the facility. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/9/23, indicated R7 was cognitively intact. During an interview on 10/2/23 at 1:12 p.m., R7 stated they never received statements from the facility for their personal trust account. During an interview on 10/4/23 at 3:13 p.m. the administrator confirmed resident trust account statements were not sent out since his start date of 1/3/23. The facility had 58 residents with a trust account at the facility. Residents and/or their representative should receive quarterly trust account statements. The Trust Fund Monthly Summary, dated 10/4/23, identified there were 58 residents with current trust accounts at the facility, however, not all residents residing in the facility were identified to have a trust account.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents with trust accounts received quarterly statements for 1 of 1 residents (R7) reviewed for resident funds. This had the potential to affect 58 current and discharged residents who had personal accounts managed by the facility. Findings include: R7's quarterly Minimum Data Set (MDS) dated 8/9/23, indicated R7 was cognitively intact. During an interview on 10/2/23 at 1:12 p.m., R7 stated they never received statements from the facility for their personal trust account. 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Administrator and/or design implement measures to en practice does not recur incledivered or mailed on 10/2, and ministrator or administrator	A BUILDING 245258 E. WIND 245258 E. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 4 of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents with trust accounts received quarterly statements for 1 of 1 residents (R7) reviewed for resident funds. This had the potential to affect 58 current and discharged residents who had personal accounts managed by the facility. 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Administrator and/or designee will implement measures to ensure that this practice does not recur including; The Administrator and/or designee will implement measures to ensure that this practice does not recur including; The administrator was trained on the policy was reviewed. The administrator was trained on the policy regarding providing trust fund statements at least quariery. Administrator and/or designee will imp

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245258	B. WING _		10/05/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE COMPLÉTION
F 568	Continued From pareceived.	ge 5	F 50	 effectiveness of these actions i Audits identifying trust functions statements were provided to residents/families will be comparaterly beginning in January the 4th quarter of 2023. Audit results will be brough QAPI committee quarterly for refurther recommendation. 	leted 2024 for at to the eview and
	S483.10(f)(10)(vi) A The facility must pu otherwise provide a Secretary, to assure funds of residents of	ity of Personal Funds 0)(vi) assurance of financial security. Irchase a surety bond, or assurance satisfactory to the e the security of all personal deposited with the facility. NT is not met as evidenced	F 5	Completion Date: November 20	0, 2023
	facility failed to ensite to or greater than the facility. This has current and dischard personal accounts. Findings include: The Bond Transact identified the facility bond that was issued insurance company. The Trust Fund Modindicated the facility.	and document review, the ure the surety bond was equal ne resident funds entrusted to d the potential to affect all 58 ged residents who had managed by the facility. ion Summary dated 10/1/23, a had a \$25,000.00 surety ed by Nationwide Mutual of the counts at the facility.		F: 570 It is Franciscan Health policy to provide a surety bond enough to cover the balance of personal funds. Administrator and/or designee implement corrective action for residents affected by this pract • A surety bond was request \$60,000.00 to cover the balance resident trust account for 10/01. Administrator and/or designee residents having the potential to affected by this practice includi. • All residents who have trust accounts have the potential to	large f resident's will all ice by: ed for e of the 1/2023. will assess o be ng: st fund

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY IPLETED
		245258	B. WING _			C 05/2023
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2020
				3910 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ER		DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE
F 570	as \$44,433.61. During an interview administrator stated balance was \$31,94 bond was for \$25,0	on 10/4/23 at 3:13 p.m., the d the total trust account 47.85 and the facility surety 00.00, which did not cover the nt balance made up of funds	F 57	by deficient practice. Administrator and/or designee wimplement measures to ensure practice does not recur including. The administrator was trained surety bond requirements and with the surety bond covers the trust account balance. Administrator and/or designee with corrective actions to ensure the effectiveness of these actions in surety bond amount conducted monthly by the administrator and surety bond amount below the surety below	hat this don deligensure fund fund will be strator to e remains eginning to the	
	Comprehensive Ass CFR(s): 483.20(b)(sessments & Timing 1)(2)(i)(iii)	F 63	Completion Date: November 20, 36	2023	11/20/23
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's				
	§483.20(b)(1) Residueled A facility must make assessment of a re	chensive Assessments ident Assessment Instrument. e a comprehensive sident's needs, strengths, nd preferences, using the				

		OMPLETED				
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	PROVIDER OR SUPPLIER SCAN HEALTH CENTI	ER	_ I	STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 636	by CMS. The assethe following: (i) Identification and (ii) Customary routing (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behad (vii) Psychological voluments (ix) Continence. (x) Disease diagnost (xi) Dental and nutrous (xii) Activity pursuito (xii) Activity pursuito (xii) Activity pursuito (xii) Discharge pland (xvii) Discharge pland (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation (xviii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The addition of the care areas to the Minimum Data (xviii) Documentation assessment of a restrict the frames prescribed and nonlic members on all shift (xiii) of this section (xiiii) of this section (xiiii) of this section (xiiii) of this section (xiiiii) of this section (xiiiiii) of this section (xiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	nt instrument (RAI) specified sement must include at least I demographic information ne. Ins. vior patterns. It well-being. I coning and structural problems. It is and health conditions. It is and procedures. It is and procedures. In of summary information onal assessment performed riggered by the completion of Set (MDS). In of participation in assessment process must vation and communication is well as communication with ensed direct care staff		536		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED	
		245258	B. WING _			D5/2023	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802			
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F 636	excluding readmiss significant change mental condition. (I "readmission" mea following a tempora or therapeutic leave (iii) Not less than or This REQUIREMED by: Based on interview facility failed to compsychotropic medic Assessment Instruresidents (R26) rewinded the medications. Findings include: R26's annual Mining 3/8/23, identified Removed antidepressant Assessment Referon 200 of the Care Acare planning, identified for contact the care planning, identified and triggered for contact the care planning identified Started Seroquel 25 listed anxiousness, targeted behaviors. R26's Psychoactive Form dated 5/30/25	lar days after admission, sions in which there is no in the resident's physical or For purposes of this section, are a return to the facility ary absence for hospitalization e.) are every 12 months. Note every 12 months. Note and document review, the aprehensively assess cations using the Resident ment (RAI) process for 1 of 5 riewed for unnecessary. The prehensive of antipsychotic and severe cognitive exceived 7 days of antipsychotic and medication during the ence Date (ARD). Section Verea Assessment (CAA) and tiffed psychotropic drug use ompletion. The prehensive of the prehe	F 6	F: 636 It is Franciscan Health Cerpolicy to assess residents on psycmedications. Director of Nursing and/or designe implement corrective action for resR26 affected by this practice by: CAA's will be completed for R'when receiving 7 days of antipsycland antidepressant medication dur ARD period. Director of Nursing and/or designerassess residents having the poten be affected by this practice includire. All residents receiving antipsycland/or antidepressant medications the ARD period are at risk of triggeral CAA's to be completed. Director of Nursing and/or designeration implement measures to ensure the practice does not recur including: Education provided to staff responsible that putting "refer to an assessment" is not acceptable documentation. CAA training provi	hotropic e will at this e will et at this nother		
	R26's medical reco	rd lacked evidence CAA's had		MDS coordinator.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245258	B. WING _			C / 05/2023
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F 641	During an interview registered nurse (Received psychotro and stated the CAA was not completed. During an interview director of nursing and CAA's completed for because they had recause they had recause they had recause they had recause of Assess CFR(s): 483.20(g). §483.20(g) Accurate The assessment meresident's status. This REQUIREMENT of the properties of the facility of the passed on observative review, the facility of Minimum Data Set to reflect restraint of R24, R38); and failed.	on 10/4/23 at 2:51 p.m., 2N)-C confirmed R26 had pic medication during the ARD for psychotropic medications. on 10/5/23 at 2:07 p.m., the stated R26 did not have any or psychotropic medication not triggered for completion. Manual dated 10/19, identified are to be completed within 14 completion of the ARD period.	F 6	Director of Nursing and/or design monitor corrective actions to eneffectiveness of these actions in Random audits of CAA documentation will be completed Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then resident weekly x 2 weeks, and monthly thereafter beginning the November 6, 2023. Audit results will be brought QAPI committee quarterly for refurther recommendation. Completion Date: November 200 Director of Nursing and/or design implement corrective action for R10, R24 and R38 affected by the practice by: Resident's R10, R24, and R34 and R35 affected in R24, and R36 affected in R36 a	sure the icluding: d by the one then e week of to the eview and , 2023 Center's iding. Inee will resident this R38 MDS	11/20/23
	Restraints: R10: R10's quarterly Minimum Data Set (MDS) dated 8/16/23, indicated R10 was cognitively intact.			will be reviewed and accurately regarding mobility bars for assist bed mobility and not as restrain Resident to the restrain of the restrain	stance with ts. dementia 03.90)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802	ODE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
rail, was marked da On 10/3/23 at 2:12 bed had a hand rail stated the bed rails bed. R24: R24's quarterly MD3 R24 had severe cog section P0100 Phys was marked daily us During an observati R24 was in bed. R2 rails on the bed in us During an interview nursing assistant (N so R24 could partice most of the work, be the bed when being R38: R38's admission MI R38 was cognitively Physical Restraints, use. During an observati R38 was not in their rail attached to the I During an interview trained medication as	D Physical Restraints, A. bed ally use. p.m., R10 was in bed. The on each side of the bed. R10 helped them move around in S dated 8/16/23, indicated gnitive impairment. MDS sical Restraints, A. bed rail, se. Ion on 10/2/23 at 2:27 p,m., 24's bed had two quarter side apright potion. on 10/4/23 at 1:35 p.m., NA)-E stated R24 had bedrails, ipate in bed mobility. Staff did ut R24 usually grabbed onto prepositioned on to their side. DS dated 8/2/23, indicated a intact. MDS section P0100, A. bed rail, was marked daily ion on 10/5/23 at 11:32 a.m., a room. R38's bed had a hand	F 6	R24's active diagnosis. Director of Nursing and/or of assess residents having the be affected by this practice All residents who have for turning and repositioning potential to be affected by the Director of Nursing and/or of implement measures to enspractice does not recur inclusional formulation of the complete the Mobility Rai prior to first use, annually, a significant change in conditional formulation of the Restraints/Devices MDS General Observations rails will no longer be used with mobility bars. Resident's diagnosis list reviewed by MD during rout add/delete any diagnosis. Director of Nursing and/or of monitor corrective actions to effectiveness of these actions. Director of Nursing and/or of monitor corrective actions to effectiveness of these actions. Andom audits of current assessments including mobility designee 5 resident week, 3 residents/week x 2 one resident weekly x 2 weemonthly thereafter beginning November 6, 2023. Audit results will be brought of the properties of the propertie	e potential to including: mobility rails that the his practice. It lesignee will sure that this uding: RN Managers il assessment and with any ion. It section of the regarding bed for residents that the his including: entity rails be the his including: entity rails be the weeks, then eks, and then including the week of ught to the his including the week of the wee	

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F 641	registered nurse (Rot used restraints Side rails and hand and were not consinot aware of why threstraints. The Centers for Me (CMS) Long-Term Assessment Instrudated 10/19, outline "SECTION P: RES which directed to rewas restrained by a the seven day look physical restraint we "Any manual methodevice, material or adjacent to the resicannot remove eas movement or norm. Diagnosis: R26: R26's quarterly MD R26 had severe consection I did not inconsection I	on 10/4/23 at 2:47 p.m., RN)-C stated the facility had on any residents in the facility. I rails were used for mobility dered restraints. RN-C was he rails were coded as edicare & Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual, ed a section labeled, TRAINTS AND ALARMS," ecord the frequency a resident any of the listed devices during back period. A definition of ras provided which outlined, and or physical or mechanical equipment attached or dent's body that the individual sily, which restricts freedom of all access to one's body." PS dated 8/30/23, indicated gnitive impairment. MDS clude a diagnosis of dementia. RS desheet included a diagnosis of dementia should	F	Completion Date: November 1	per 20, 20)23	

STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245258	B. WING			C 05/2023
	OVIDER OR SUPPLIER AN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802		
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а		ige 12 ssessment of each resident ndicated the MDS coordinator	F 6	41		
F 677 A	oding responsibilit 0100.	ies included section I and I for Dependent Residents	F 6	77		11/20/23
ospTbErdre F ReinaDd Rs DRfa DR	ut activities of dail ervices to maintail ersonal and oral his REQUIREMENT. Based on observative with the facility of aily living (ADL's) eviewed for ADL's indings include: 24's quarterly Miny 16/23, identified on the facility of an observative ecline and non-Alian ecline and non-Alian ecline and non-Alian ecline and observative R24's face of ace, chin, and upport of the face, chin, and uppor	tion, interview and document ailed to perform activities of for 1 of 6 residents (R24) mimum Data Set (MDS) dated R24 had severe cognitive quired extensive physical person personal hygiene. It progressive neurological zheimer's dementia. ted 9/7/23, instructed staff to laily. tion on 10/2/23 at 2:27 p.m., tubble along the sides of his		F: 677 It is Franciscan Health C policy to provide ADL care for de residents per our resident's plan Director of Nursing and/or design implement corrective action for r R24 affected by this practice by: R24 will be shaved daily. R24's care plan reviewed on 10/19/23, currently reflects to be daily and is assigned to each shi Director of Nursing and/or design assess residents having the pote be affected by this practice inclue. All residents who are dependent affected by deficient practice. Director of Nursing and/or design implement measures to ensure the practice does not recur including. Education provided to staff or reviewing care plan/care stream assigned tasks on CNA meeting.	pendent of care. nee will esident on the ding: dent on the to be the man to be the form of the form o	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X3) DATE SUF		
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	TO VIDENCE OF COURT			3910 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ER		DULUTH, MN 55802		
04.0.15	CLINANA DV. CTA	TEMENT OF DEFICIENCIES	<u> </u>			0.45)
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F 677	Continued From pa	ige 13	F 67	77		
	R27 continued to he face, his hair was well. During an observat	ion on 10/3/23 at 4:00 p.m., have whisker stubble on his vet and combed back. ion on 10/4/23 at 11:01 a.m., the dining room seated in a		 12-2023. Person centered policy read copies given to staff during me All residents who need assistated with toileting will have their care planed in the reviewed and updated as needed. 	eeting. Ince	
		d, glasses on, with noticeable		Director of Nursing and/or designe monitor corrective actions to ensure effectiveness of these actions included	re the	
	R27 was dressed w	ion on 10/5/23 at 11:35 a.m., with glasses on. R27 continued bble on the sides of his face,		 Random audits identifying sharesident's care plan will be compled Director of Nursing/designee 5x/week, 3x/week x 2 weeks, then on weekly x 2 weeks, and then month 	s identifying shaving per in will be completed by g/designee 5x/week x 1 weeks, then once	
	nursing assistant (Nature) shaved, but they be shaved every day. It shaving residents la	on 10/4/23 at 1:35 p.m., NA)-E stated R27 was not elieved he was normally NA-E stated a therapist was ater that afternoon so R27 y the therapist later.		thereafter beginning the week of November 6, 2023. • Audit results will be brought to QAPI committee quarterly for reviet further recommendation.	the ew and	
	registered nurse (R	on 10/5/23 at 12:14 p.m., N)-A stated they would expect daily because that was their		Completion Date: November 20, 2	U23	
	director of nursing splanned for R27 to should be shaved of shave R27, that should a days worth of which	on 10/5/23 at 2:09 p.m., the stated (DON) if it was care be shaved daily then R27 daily. If the NA's are not able to ould be reported to the nurse nentation. R27 had more than sker growth. ostomy Care and Suctioning	F 69	95		11/20/23
	§ 483.25(i) Respira tracheostomy care	tory care, including and tracheal suctioning.				

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F 695	needs respiratory of care and tracheal scare, consistent with practice, the composare plan, the resident days. This REQUIREME by: Based on observative review the facility fawas changed according include: R10's quarterly Mir 8/16/23, indicated lays include chronic respiratory. R10's undated Resorder for oxygen 1 levels above 90 pewas no order for oxygen 1 levels above 90 pewas no order for oxygen for comformal considering an observative R10 was in bed we tubing with oxygen connected to a large connected to	resure that a resident who care, including tracheostomy suctioning, is provided such the professional standards of rehensive person-centered lents' goals and preferences, subpart. Note in interview and document ailed to ensure oxygen tubing reling to policy for 1 of 1 viewed for respiratory care. In imum Data Set (MDS) dated R10 was cognitively intact. In dend stage renal disease and failure. In included an ailter per minute to keep oxygen recent three times daily, there are tygen tubing to be changed Ited 8/16/23, instructed the use ort care. Ited 8/16/23 at 2:49 p.m., rearing nasal cannula oxygen running. The tubing was ge oxygen concentrator in the ot a visible change date on	F 6	F: 695 It is Franciscan Health Copolicy to change oxygen tubing a and at least weekly. Director of Nursing and/or design implement corrective action for reR10 affected by this practice by: R10's oxygen tubing was changed weekly-Sunday-during NOC shift Director of Nursing and/or design assess residents having the potential beaffected by this practice include. All residents receiving oxygerisk for not having the tubing change weekly per facility policy. Director of Nursing and/or design implement measures to ensure the practice does not recur including. All residents with oxygen use orders reviewed to ensure an order or place to change tubing weekly per orders were obtained and entered residents without active orders to	s needed nee will anged on mar for hee will hat this hat this hat this hat on r policy d for	
	•	tion on 10/3/23 at 1:30 p.m., th nasal cannula on and		tubing weekly. • Education provider to current		

FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 15 oxygen running. During an observation on 10/04/23 at 8:26 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: Random audits identifying oxygen tubing being changed will be completed	EMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′		E CONSTRUCTION	` '	E SURVEY IPLETED
RAME 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) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACHE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE DEFICIENCY) F 695 Continued From page 15 Shift staff regarding nightly duties assigned to them and a copy of NOC nurse task list printed and posted in med room. Shift staff regarding nightly duties assigned to them and a copy of NOC nurse task list printed and posted in med room. During an observation on 10/04/23 at 8:26 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: • Random audits identifying oxygen tubing being changed will be completed			245258	B. WING				
F 695 Continued From page 15 oxygen running. During an observation on 10/04/23 at 8:26 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: Random audits identifying oxygen tubing being changed will be completed			ER		39	10 MINNESOTA AVENUE		
oxygen running. Shift staff regarding nightly duties assigned to them and a copy of NOC nurse task list printed and posted in med room. During an observation on 10/5/23 at 11:38 a.m., R10 was in bed with nasal cannula on and oxygen running. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: Random audits identifying oxygen tubing being changed will be completed	RÉFIX (I	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
(RN)-B stated it was the cart nurse's responsibility to ensure oxygen tubing was dated and changed once a week. There was not a weekly oxygen tubing change ordered for R10, and explained the order should be in place because that was how the due date showed up on the medication administration record (MAR). RN-B entered R10's room and located a sticker on the oxygen tubing change was overdue and the tubing needed to be changed to ensure adequate airflow and to prevent infection. During an interview on 10/5/23 at 2:11 p.m., the director of nursing (DON) stated all residents with oxygen should have a weekly tubing change ordered. A task was assigned each night with a list of who needs the task completed, so oxygen tubing should have been changed for R10 even without a nursing order. The DON expected an order for tubing change to be obtained, oxygen tubing to be labeled and dated, and changed at minimum, once a week. This was important for preventing infection and to ensure residents was to such a weekly x 2 weeks, and then monthly thereafter beginning the week of November 6, 2023. • Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion Date: November 20, 2023 Completion Date: November 20, 2023 The facility policy Oxygen Concentrator dated 10/22, directed staff to change nasal cannula	During R10 voxyge During R10 voxyge On 10 (RN)-to end once tubing order the diadmin room dated oxyge order list of tubing without order tubing without the function of the diadmin order tubing without the diadmin order tubing without the function of the diadmin order tubing without t	gen running. Iring an observation was in bed with year running. Iring an observation of was in bed with year running. In 10/5/23 at 11:45 N)-B stated it was ensure oxygen to be in percentage or detection. It is a week. Therefore a week. Therefore a week. Therefore a week. Therefore and located a sted 9/25/23. RN-lange was overduranged to ensure event infection. It is an interview extention of nursing (year should have been and located a steep of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection. It is a week was a contraction of the percent infection of th	ion on 10/04/23 at 8:26 a.m., h nasal cannula on and ion on 10/5/23 at 11:38 a.m., h nasal cannula on and a.m., registered nurse is the cart nurse's responsibility ubing was dated and changed is was not a weekly oxygen ared for R10, and explained the place because that was howed up on the medication rd (MAR). RN-B entered R10's in sticker on the oxygen tubing is a stated R10's oxygen tubing is and the tubing needed to be adequate airflow and to a weekly tubing change is assigned each night with a see task completed, so oxygen is been changed for R10 even and the tubing change is assigned each night with a see task completed, so oxygen is been changed for R10 even and the tubing change and dated, and changed at week. This was important for and to ensure residents had boxygen Concentrator dated		95	assigned to them and a copy of NC nurse task list printed and posted in room. Director of Nursing and/or designed monitor corrective actions to ensure effectiveness of these actions inclue. Random audits identifying oxygotubing being changed will be complete by Director of Nursing/designee 5 residents/week x 1 week, 3 residents/week x 2 weeks, then one resident weekly x 2 weeks, and the monthly thereafter beginning the work November 6, 2023. Audit results will be brought to QAPI committee quarterly for review further recommendation.	e will e the iding: leted the wand	

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F 757	frequently. Drug Regimen is F	unless needed more ree from Unnecessary Drugs	F 69		11/20/23
33-0	Each resident's dru	essary Drugs-General. Ig regimen must be free from In the control of the contro			
	§483.45(d)(1) In ex duplicate drug there	cessive dose (including apy); or			
	§483.45(d)(2) For e	excessive duration; or			
	§483.45(d)(3) With	out adequate monitoring; or			
	§483.45(d)(4) With	out adequate indications for its			
	·	e presence of adverse ch indicate the dose should be nued; or			
	stated in paragraph section.	combinations of the reasons is (d)(1) through (5) of this			
	Based on observation review the facility facilit	tion, interview and document ailed to implement effect monitoring for 1 of 2 ewed for anticoagulant use.		F: 757 It is Franciscan Health C policy to provide monitoring for ron anticoagulation therapy per o resident's plan of care.	esidents
		imum Data Set (MDS) dated diagnoses of hypertension and		Director of Nursing and/or designable implement corrective action for rR12 affected by this practice by: R12's Care Plan was review	esident

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	JLTIPLE CONSTRUCTION ONE (X3) DATE SURV COMPLETED			
		245258	B. WING	i			C 05/2023
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2020
				39 [.]	10 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ΓER		DU	JLUTH, MN 55802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 757	Continued From p	age 17	F 7	757			
	peripheral vascula	r disease or peripheral arterial			updated as necessary to reflect		
		cognitively intact and an			appropriate anticoagulant use and	orders	
		used during the last seven			for monitoring every shift on 10/06		
		ompletion of the MDS.					
		•			Director of Nursing and/or designed	e will	
	R12's current prov	ider orders dated 3/4/22,			assess residents having the poten		
	directed staff to ad	lminister Xarelto (a blood			be affected by this practice includi	ng:	
	thinner that can or	nly be monitored by			 All residents who are on 		
	observation) 20 m	illigrams (mg) daily.			anticoagulants have the potential t	o be	
					affected by this deficient practice.		
	.	ated 5/25/22, failed to identify					
		s related to anticoagulant use			Director of Nursing and/or designed		
	or that R12 was or	n anticoagulant.			implement measures to ensure that	at this	
					practice does not recur including:		
	_	n 10/5/23 at 11:13 a.m., nursing			 An anticoagulant use policy wi 	ll be	
	\	tated the nursing assistants			created and updated as needed.		
		medical record to know how to			All residents who receive		
		or each resident. There was			anticoagulants had their care plans	S	
	,	unit that was on a blood			reviewed to assure that accurate		
		d closer monitoring. NA-A			information is in place to reflect		
		edical record that nurse			anticoagulant use. Updates will be	made	
		cess to and indicated R12 was			as needed.		
	not on blood thinne	C15.			Director of Nursing and/or designe	o will	
	During interview of	n 10/5/23 at 11:53 a.m.,			monitor corrective actions to ensur		
		RN)-A stated R12 was on			effectiveness of these actions incli		
	,	the medication orders. No			 Random audits identifying that 	•	
		electronic medical record			monitoring is in place and resident		
		on blood thinners so no other			plan reflects anticoagulant use will		
		are close monitoring for			completed by Director of		
	bleeding/bruising v	•			Nursing/designee 5 residents/wee	k x 1	
					week, 3 residents/week x 2 weeks		
	During interview of	n 10/5/23 at 11:59 a.m., the			one resident weekly x 2 weeks, an	,	
		(DON) stated there should be			monthly thereafter beginning the w		
		aced to monitor for			November 6, 2023.	_	
		effects such as bleeding and			 Audit results will be brought to 	the	
	_	nould also be an intervention in			QAPI committee quarterly for review		
		ll staff that work with R12 are			further recommendation.		
	•	ased risk of bleeding and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COM	E SURVEY IPLETED
		245258	B. WING			C 05/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 8910 MINNESOTA AVENUE DULUTH, MN 55802	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	Continued From pa bruising. All staff w	ge 18 ere expected to monitor for	F 757	Completion Date: November 20, 2	2023	
	A policy for anticoacted but not p	e resident safe. gulant monitoring was rovided.				
	Free from Unnec Packers (c) (3)	sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 758			11/20/23
	affects brain activiti processes and beh	chotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following				
	•	hensive assessment of a must ensure that				
	psychotropic drugs unless the medicati	dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented d;				
	drugs receive gradu behavioral intervent	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	psychotropic drugs unless that medicat	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	TIPLE CONSTRUCTION	l \ /	E SURVEY IPLETED
		245258	B. WING		1	C 05/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COD 3910 MINNESOTA AVENUE DULUTH, MN 55802)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 758	are limited to 14 da §483.45(e)(5), if the prescribing practition appropriate for the beyond 14 days, he rationale in the resident the duration §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practition the appropriatenes. This REQUIREMED by: Based on interview facility failed provide non-pharmalogical admininistration of medications and id of 5 residents (R34 behavior and side of the sidents reviewed use. Findings include: R34's significant check (MDS) dated 8/4/23 dementia and Park cognitively intact are cares. The cooresp (CAA) dated 8/4/23 da	d; and l orders for psychotropic drugs lys. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their dent's medical record and in for the PRN order. l orders for anti-psychotic of 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. No is not met as evidenced of and document review, the e evidence of interventions prior to the as-needed (PRN) psychotropic entify behavior monitoring for 1 orders; and failed to identify effect monitoring 1 of 5 (R26) for unnecessary medication or ange Minimum Data Set or inson's disease. R34 was or had behaviors of rejection of conding Care Area Assessment or inson's disease. R34 was or had behaviors of rejection of conding Care Area Assessment or inson's disease. R34 was or had behaviors and		F: 758 It is Franciscan Health policy to provide residents with appropriate medications, mon non-pharmacological interventage implement corrective action for R26 and R34 affected by this R26 care plan updated on to include monitoring for therateffects of and side effects of antipsychotic medications and behaviors that indicate its use R26 had an AIMS assess completed on 10/23/2023 and completed semiannually and FR34 passed away on 10/0000 Director of Nursing and/or desassess residents having the pube affected by this practice incompleted by the practice in the practic	haitoring, and tions. signee will practice by: 10/6/2023 peutic prescribed specific ment will be PRN. 04/2023.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	. ,	E SURVEY PLETED
		245258	B. WING			C 05/2023
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP	•	00,2020
				3910 MINNESOTA AVENUE		
FRANCIS	SCAN HEALTH CENT	ER		DULUTH, MN 55802		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	χ (EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETION DATE
F 758	Continued From pa	age 20	F 7	758		
	R34's care plan da	ted 11/2/22, indicated a care		All residents who are o	n	
	•	alth behaviors was initiated but		antipsychotics have the pot		
	lacked goals and in assist the resident	nterventions staff would try to back to baseline.		affected by this deficient pr		
				Director of Nursing and/or	designee will	
	R34's Doctor's Ord	lers form dated 8/17/23,		implement measures to en	•	
	directed staff to ad	minister Alprazolam oral tablet		practice does not recur inc	luding:	
		tablet by mouth every 4 hours		 All residents taking any 	/ antipsychotic	
	•	c attack or restlessness. The		medications will be assess		
		pharmolocical interventions to		AIMS scale by 11/03/2023,	if needed, and	
	use prior to admini	•		semiannually thereafter.		
	antipsychotic medi	cations.		All residents who received		
	D24's stastassis as	adiaatian adminiatratian raaard		antipsychotics had their ca	•	
		edication administration record		reviewed to include target be	,	
	,	23 to 9/30/23, indicated R34 m on 9/17/23, and 9/23/23, for		non-pharmacological intervential side effects of me	•	
	•	v up documentation of		Updates will be made as no		
		dical record lacked evidence		 Emar orders will be en 		
		ited or non-pharmological		monitor daily for behaviors		
		pted prior to medications to		effects of psychotropic med		
		cation was needed.		Nurse Managers will be		
				the use of antipsychotics a		
	During an interview	on 10/5/23 at 11:53 a.m.,		of target behaviors, non-ph	armacological	
	,	RN)-A stated prior to giving a		interventions, and potential	side effects of	
		medication there were		medications.		
		cal behavioral interventions that				
		npted and documented prior to		Director of Nursing and/or	•	
		given. RN-A reviewed the		monitor corrective actions to		
	•	gress notes and stated there		effectiveness of these action	•	
		f any attempts to address prior		Random audits identify monitoring is in place and recorder.	•	
		iven. There should be as distraction, repositioning or		monitoring is in place and reflects antipsychotic		
	1 on 1 activities pe	, ,		completed by Director of	ASC WIII DC	
	i on i activities pe	11011110u.		Nursing/designee 5 resider	nts/week v 1	
	During an interview	on 10/5/23 at 11:59 a.m. the		week, 3 residents/week x 2		
		(DON) reviewed R34's EMAR		one resident weekly x 2 we	,	
		and stated there was no		monthly thereafter beginning	•	
	documentation of r			November 6, 2023.	.	
		symptoms exhibited when the		Audit results will be bro	sught to the	

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	O DATE SURVEY COMPLETED
		245258	B. WING _			C 10/05/2023
	/IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
PF ex no ma be	pected nursing values of the pected nursing values of the pected nursing values of the pected nursing given. Nursing given.	age 21 medication was given. DON would document cal interventions and symptom to antipsychotic medication ng would then document the red after medication was given.	F 7	QAPI committee quarterly for further recommendation. Completion Date: November		
Rande	d severe cognitication antiper 26's undated, factorial disorder for Seroquetime. 26' care plan dated monitor R26 for fects from prescribed for and 26's medical received for an antiper an interview 16's stated at risk 26's are plan. Behinpleted for residual received for received	os dated 8/30/23, identifed R26 we impairment and was sychotic medication. cesheet included diagnoses of disorder, dementia, and rs. //sician Order Review included uel 25 milligrams (mg) daily at ed 7/17/23, did not instruct staff therapeutic effects of or side ribed antipsychotic medication, that behaviors seroquel was the facility was monitoring for. ord lacked evidence R26 had r antipsychotic medication side in Abnormal Involuntary (assessment to monitor for antipsychotic medication) ov on 10/5/23 at 11:56 a.m., a medications should be put on avior monitoring should be dents on antipsychotics to see was working or if the dose aged. The facility did not				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	` '	E SURVEY IPLETED
		245258	B. WING _			C ' 05/2023
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802	1 107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 758	During an interview RN-A stated resider antipsychotic medic AIMS two times a y prescribed antipsyc R26 did not have a plan should have in therapeutic effect a antipsychotic medic During an interview stated routine AIMS completed on all reantipsychotic medic medication administ should have included	have the ability to trigger ation if needed. on 10/5/23 at 12:10 a.m., ats should be monitored for ation. The facility completed ear on residents with hotic medication; however, completed AIMS. R26's care cluded behavior monitoring for and side effect monitoring for	F 75	58		
F 880 SS=D	9/11/23, indicated: promitored daily and adverse side expensions should be DISCUS or AIMS stevery 6 months. The PRN medication us Infection Prevention CFR(s): 483.80(a)(s) §483.80 Infection CFR(s): 483.80(a)(s) §483.80 Infection prevention designed to provide comfortable environ	n & Control 1)(2)(4)(e)(f)	F 88	30		11/20/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X	(3) DATE SURVEY COMPLETED
		245258	B. WING			C 10/05/2023
	PROVIDER OR SUPPLIER SCAN HEALTH CENT	ER		STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	5.475
F 880	program. The facility must es and control program a minimum, the foll §483.80(a)(1) A system of communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of survices possible communicable disereported; (iii) When and to who communicable disereported; (iii) Standard and the to be followed to provide (iii) When and how is resident; including to the followed, and (B) A requirement to least restrictive possible communicable disereported; (iii) Standard and the followed to provide (A) The type and do the followed, and (B) A requirement to least restrictive possible communicable disereported; (iiii) Standard and the followed to provide (A) The type and do the followed, and (B) A requirement to least restrictive possible communicable disereported; (iii) Standard and the followed to provide (A) The type and do the followed to provide (B) A requirement to least restrictive possible communicable disereported; (III) Standard and the followed to provide (B) A requirement to least restrictive possible communicable disereported; (III) Standard and the followed to provide (B) A requirement to least restrictive possible communicable disereported).	tablish an infection prevention in (IPCP) that must include, at owing elements: Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual if upon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a		880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING) COM	E SURVEY IPLETED
		245258	B. WING			C 05/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3910 MINNESOTA AVENUE DULUTH, MN 55802	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	disease or infected contact with reside contact will transm (vi)The hand hygic by staff involved in §483.80(a)(4) A sylidentified under the corrective actions §483.80(e) Linens Personnel must hat transport linens so infection. §483.80(f) Annual The facility will consider the facility will consider the facility will consider the facility were effectively satisfied on the facility of the residents for R37) observed during observation certified occupation entered R18's room assist to stand, R1 After the transfer of hallway without satisfied observation assistant (NA)-B gassistant (NA	loyees with a communicable d skin lesions from direct ents or their food, if direct nit the disease; and ene procedures to be followed a direct resident contact. In the disease; and ene procedures to be followed a direct resident contact. In the disease; and ene procedures to be followed a direct resident contact. In the facility's IPCP and the taken by the facility. In andle, store, process, and end as to prevent the spread of enduct an annual review of its their program, as necessary. ENT is not met as evidenced ention, interview, and record failed to ensure resident lifts entitize prior to being used on a 3 of 3 residents (R18, R31, ring lift transfers. In on 10/2/23 at 2:18 p.m., and therapy assistant (COTA)-D en, transferred R18 with the last physically touched the lift. COTA-D took the lift back to the		F: 880 It is Franciscan Hea policy to use proper sanitation mechanical lifts between resulting propers and/or dimplement corrective action R7, R18, R31 affected by the Staff caring for resident and R31 will use proper san techniques on mechanical limits be affected by this practice affected by this practice of the All residents transferred mechanical lifts have the position affected by deficient practice.	esignee will for resident is practice by: s R7, R18, itation ffts. lesignee will potential to including: I with tential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C 05/2023
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP (3910 MINNESOTA AVENUE DULUTH, MN 55802	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 880	sanitizing the lift. It sanitizing the lift. It NA-C grabbed the and entered R37's transfer R37 to the unsanitized lift to the unsanitized lift to the lift of the lift. During observation gathered the unsaroom to transfer Foready for lunch. A connected to the lift and lift. During an interview stated the lift was using it on R18, and hallway. During an interview stated the lift is sue each use, so it was needed to use it. During an interview stated he did not obecause the staff have sanitized it. Sanitized the lift at lifts were not sanitized lifts were not sani	r to commode and back without NA-B exited the room without As NA-B was exiting the room elift without it being sanitized if room. NA-C used the lift to be bed, and returned the the hallway without sanitizing it. In on 10/2/23 at 2:41 p.m., NA-D anitized lift and entered R31's R31 out of the chair and get R31 if NA-D. The surveyor sked NA-D to step out of the and then asked to sanitize the without sanitized before or after and prior to putting it in the without sanitized after as ready for the next person that without sanitized the lift prior to use that used it before NA-C should NA-C acknowledged he had not		Director of Nursing and/or of implement measures to en practice does not recur incle. All DME was disinfected the facility by staff the week 10/09/2023. Disinfecting wipes were pocket of each mechanical were none present. Education provided to a disinfecting DME between Disinfection and Resident of was reviewed with, and condirect care staff at CNA med 12-2023. Knowledge as to product is located and instruse reviewed. Director of Nursing and/or of monitor corrective actions of effectiveness of these actions. Random audits identify DME between resident use completed by Director of Nursing/designee 5x/week 3x/week x 2 weeks, then of weeks, and then monthly the beginning the week of Noveland and the production of the week of Noveland and the	sure that this luding: ed throughout k of e placed in the lift if there staff on residents. Care equipment by given to eeting held 10-where cleaning ructions for its designee will to ensure the ons including: ving cleaning of e will be at 1 week, not weekly x 2 hereafter ember 6, 2023. Sought to the for review and	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245258	B. WING			C 10/05/2023	
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 3910 MINNESOTA AVENUE DULUTH, MN 55802	DE I	10/03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	R37's chart and corhad current community During an interview director of nursing (was all staff observed practices when using from illness. The facility policy Description in the facility p	viewed R18's, R31's and affirmed none of the residents inicable diseases. on 10/4/23 at 2:28 p.m. the DON) stated their expectation is accurate infection controling lifts to protect all residents isinfection of Resident Care (22/17, identified durable would be cleaned and	F 8	80			



Electronically delivered October 17, 2023

Administrator Franciscan Health Center 3910 Minnesota Avenue Duluth, MN 55802

Re: State Nursing Home Licensing Orders

Event ID: 57E211

Dear Administrator:

The above facility was surveyed on October 2, 2023 through October 5, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082

Email: Alex.Warren@state.mn.us

Mobile: 651-279-5375 Office: 218-302-6186

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

Minnesota Department of Health

Kumalu Fiske Downing

Health Regulation Division Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 10/27/2023 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		` ′	DATE SURVEY COMPLETED	
	00865	B. WING	C IG		C 05/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE DULUTH, MN 55802						
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 000 Initial Comments		2 000				
*****ATTEI	NTION*****					
NH LICENSING	CORRECTION ORDER					
144A.10, this corrected pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Corrected requires of the number and MN Rule When a rule contain comply with any of lack of compliance, re-inspection with a result in the assess	hether a violation has been					
that may result from orders provided that the Department with	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.					
conducted at your f Minnesota Departm facility was NOT in Licensure and the f issued. Please indic	7S: 23, a licensing survey was acility by surveyors from the nent of Health (MDH). Your compliance with the MN State ollowing correction orders are cate in your electronic plan of a reviewed these orders and					
•	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

Electronically Signed

10/26/23

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00865	B. WING		10/0	5/2023
	PROVIDER OR SUPPLIER	3910 MINI	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	The following compethe survey and no list H52586007C (MNS H52586009C (MNS H52586005C (MNS H52586006C (MNS H52586010C (MNS H52586006C (MNS H525	laints were reviewed during censing orders were issued: 3870) (90854) (93869) (93871)	2 000			

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 2 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00865	B. WING		C 10/05/2023	
FRANCISCAN HEALTH CENTER 3910 MIN		DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	corrected prior to el Minnesota Department PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM! CORRECTION FORMINNESOTA STATE AND	e date your orders will be ectronically submitting to the ent of Health. RD THE HEADING OF THE WHICH STATES, NOF CORRECTION." THIS ERAL DEFICIENCIES ONLY. RON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES. Eate.mn.us/divs/fpc/profinfo/informate licensing orders are estached Minnesota with orders being submitted to Although no plan of correction at estatutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the endate, the date your orders will be electronically submitting to eartment of Health. The facility and therefore a signature is pottom of the first page of	2 000			
2 540	Resident Assessme		2 540			11/20/23
	<u>-</u>	ment. A nursing home must ensive assessment of each				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00865	B. WING		C 10/05/2023	
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
FRANCISCAN HEALTH CEN	TER	NESOTA AVI MN 55802	ENUE		
PREFIX (EACH DEFICIEN	/EAGLI DEELGIENIGY/AUTOT DE DDEGEDED DY/ELUT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETE	
capability to perforsignificant impairs nursing assessmed Minnesota Statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used resident assessmed to develop, comprehensive performance of the second statut 15, may be used to develop, comprehensive performance of the second statut 15, may be used to develop assessmed to develop, comprehensive performance of the second statut 15, may be used to develop assessmed to develop, comprehensive performance of the second statut 15, may be used to develop assessmed to develop a	which describes the resident's rm daily life functions and nents in functional capacity. A ent conducted according to es, section 148.171, subdivision as part of the comprehensive ent. The results of the esident assessment must be eview, and revise the resident's an of care as defined in part nation gathered. The esident assessment must e following information: defined conditions and prior atus measurement; and mental functional status; and physical impairments; status and requirements; atments or procedures; at psychosocial status; potential; ition;	2 540			
K. rehabilitati L. cognitive s M. drug thera N. resident p	tatus; by; and				
by: Based on intervie facility failed to company psychotropic med Assessment Insti	ment is not met as evidenced w and document review, the mprehensively assess ications using the Resident ument (RAI) process for 1 of 5 eviewed for unnecessary		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED		
		00865	B. WING		I	C 10/05/2023	
	NAME OF PROVIDER OR SUPPLIER STREET AD 3910 MIN DULUTH			STATE, ZIP CODE ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 540 Con	tinued From pa	age 4	2 540				
3/8/impland Ass 020 care had star liste	23, identified Rairment. R26 reantidepressant essment Refere 0 of the Care A planning, identified for countable ted Seroquel 25	eled document identified R26 5 mg daily on 12/21/22, and restlessness and sleep as					
Fori	m dated 5/30/22 raline for the ta	Medication Informed Consent 2, indicated R26 was taking rget behavior of decreased					
		rd lacked evidence CAA's had r psychotropic medication.					
regi rece and	stered nurse (Reived psychotro	on 10/4/23 at 2:51 p.m., RN)-C confirmed R26 had pic medication during the ARD for psychotropic medications.					
dire any	ctor of nursing CAA's complet	on 10/5/23 at 2:07 p.m., the (DON) stated R26 did not have ed for psychotropic medication not triggered for completion.					
trigg	gered CAA's we	Manual dated 10/19, identified re to be completed within 14 completion of the ARD period.					
		THOD OF CORRECTION: nee could review and revise					

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	COMPLETED	
		00865	B. WING		C 10/05/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		3910 MINI	NESOTA AVE			
FRANCI	SCAN HEALTH CENTE	DULUTH,	MN 55802			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 5	2 540			
	policies and proced Minimum Data Set required information or procedure chang medical records to assessments. Audit specific. The results taken to the QAPI compliance or the negative compliance or the negative compliance.	ures related to performing (MDS) and the collection of a; and educate staff to policy es; and audit other residents determine accuracy of their is should be measurable and sof those audits should be committee to determine leed for further monitoring. R CORRECTION: Twenty-one				
2 550		Subp. 4 Comprehensive	2 550			11/20/23
	home must examine quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the of the assessment.				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview, and document ailed to ensure the completed (MDS) was accurately coded se for 3 of 3 residents (R10, ed to include a diagnosis for 1 reviewed for MDS accuracy.		Corrected		

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 6 of 20

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
		00865	B. WING		10/0	; 5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
FRANCIS	SCAN HEALTH CENTE	ER	NESOTA AVE MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 6	2 550			
	MDS section P0100 rail, was marked da	Physical Restraints, A. bed ily use.				
	bed had a hand rail	p.m., R10 was in bed. The on each side of the bed. R10 helped them move around in				
	R24 had severe cog	S dated 8/16/23, indicated gnitive impairment. MDS sical Restraints, A. bed rail, se.				
	_	on on 10/2/23 at 2:27 p,m., 24's bed had two quarter side pright potion.				
	nursing assistant (No. 1) so R24 could partice most of the work, be	on 10/4/23 at 1:35 p.m., IA)-E stated R24 had bedrails, ipate in bed mobility. Staff did ut R24 usually grabbed onto repositioned on to their side.				
	R38 was cognitively	DS dated 8/2/23, indicated intact. MDS section P0100, A. bed rail, was marked daily				
		on on 10/5/23 at 11:32 a.m., r room. R38's bed had a hand left side of the bed.				
	trained medication a	on 10/5/23 at 1:54 p.m., aide (TMA)-A stated R38 used st with transfers and bed				
	During an interview	on 10/4/23 at 2:47 p.m.,				

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 7 of 20

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	
		00865	B. WING		10/0	5/2023
	PROVIDER OR SUPPLIER SCAN HEALTH CENTE	3910 MINI	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 550	not used restraints Side rails and hand and were not conside not aware of why the restraints. The Centers for Me (CMS) Long-Term Conservation Assessment Instruct dated 10/19, outline "SECTION P: REST which directed to re was restrained by a the seven day look- physical restraint we "Any manual method device, material or adjacent to the residence cannot remove eas movement or normal Diagnosis: R26: R26's quarterly MD R26 had severe consection I did not ince R26's undated, Factor section I did not ince R26's undated, Factor femology section I did not ince R26's undated, Factor femo	N)-C stated the facility had on any residents in the facility. rails were used for mobility dered restraints. RN-C was e rails were coded as dicare & Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual, ed a section labeled, FRAINTS AND ALARMS," cord the frequency a resident ny of the listed devices during back period. A definition of as provided which outlined, ed or physical or mechanical equipment attached or dent's body that the individual fily, which restricts freedom of all access to one's body." S dated 8/30/23, indicated gnitive impairment. MDS lude a diagnosis of dementia. esheet included a diagnosis on 10/4/23 at 2:51 p.m., N)-C stated dementia should	2 550			

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 8 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		00865	B. WING		10/0	C 0 5/2023
	PROVIDER OR SUPPLIER SCAN HEALTH CENTE	3910 MINN	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED TO THE APPROPOSED CORRECTION (CROSS-REFERENCED)	D BE	(X5) COMPLETE DATE
	SUGGESTED MET The director nursing review and revise p to performing Minim collection of require staff to policy or pro other residents med accuracy of their as measurable and spe audits should be tak determine complian monitoring. TIME PERIOD FOR (21) days.	ies included section I and THOD OF CORRECTION: g (DON) or designee could colicies and procedures related num Data Set (MDS) and the ed information; and educate ocedure changes; and audit dical records to determine essessments. Audits should be ecific. The results of those ken to the QAPI committee to nce or the need for further R CORRECTION: Twenty-one	2 920			11/20/23
	comprehensive resinance home must ensure B. a resident who activities of daily living services to maintain and personal and of the by: Based on observation review, the facility faces in the services in the	is unable to carry out ing receives the necessary necessary necessary necessary and nutrition, grooming, oral hygiene. ent is not met as evidenced ion, interview and document ailed to perform activities of for 1 of 6 residents (R24)		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
		00865	B. WING	B. WING		C 10/05/2023	
	NAME OF PROVIDER OR SUPPLIER STREET AD 3910 MIN DULUTH,			TATE, ZIP CODE NUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
2 920	8/16/23, identified Fimpairment and regassistance of one properties assistance of one properties assistance of one properties and non-Alza R24's care plan data shave R24's face do During an observation R27 had whisker strace, chin, and upper During an observation R27 continued to hasides of his face, chis hair was well buring an observation R27 continued to have his hair was well buring an observation R27 was located in wheelchair, dressed whisker stubble. During an observation R27 was dressed with the stubble respectively. During an observation R27 was dressed with the stubble respectively. During an observation respectively and chin. During an interview nursing assistant (Naved, but they be shaved every day, I shaving residents in the state of	imum Data Set (MDS) dated R24 had severe cognitive uired extensive physical erson personal hygiene. I progressive neurological cheimer's dementia. The decirrence of the second staff to aily. The decirrence of the second staff to aily.	2 920	DEI IOIEINO!			
	During an interview	on 10/5/23 at 12:14 p.m.,					

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 10 of 20

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED	
		00865	B. WING			C 0 5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
EDANCIO	CAN DEALTH CENTE	3910 MINI	NESOTA AVE			
FRANCIS	SCAN HEALTH CENTE	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 SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From page	ge 10	2 920			
	•	N)-A stated they would expect daily because that was their				
	director of nursing splanned for R27 to least should be shaved deshave R27, that should be shave R27, that should be should be shave R27, that should be should	on 10/5/23 at 2:09 p.m., the stated (DON) if it was care be shaved daily then R27 aily. If the NA's are not able to ould be reported to the nurse entation. R27 had more than sker growth.				
	The DON or design who are dependent responsible staff bacare plan needs. The conduct audits of design	HOD OF CORRECTION: ee could audit resident care on staff and educate ased on the assessed and he DON or designee could ependent resident cares to al hygiene needs are met				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			11/20/23
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and nt.				
	by: Based on observation observation observation is review the facility factories were effectively san	ent is not met as evidenced on, interview, and record iled to ensure resident lifts itize prior to being used on 3 of 3 residents (R18, R31,		Corrected		

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 11 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		00865	B. WING			C 05/2023
	PROVIDER OR SUPPLIER SCAN HEALTH CENTI	3910 MIN	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21375	certified occupation entered R18's room assist to stand, R18	ng lift transfers. on 10/2/23 at 2:18 p.m., al therapy assistant (COTA)-D n, transferred R18 with the physically touched the lift. OTA-D took the lift back to the				
	During observation assistant (NA)-B gasto to stand lift, entered R31 from the chair sanitizing the lift. Nasanitizing the lift. As NA-C grabbed the land entered R37's transfer R37 to the	on 10/2/23 at 2:31 p.m., nurse thered the unsanitized assist R31's room, and transferred to commode and back without A-B exited the room without NA-B was exiting the room ift without it being sanitized room. NA-C used the lift to bed, and returned the hallway without sanitizing it.				
	gathered the unsan room to transfer R3 ready for lunch. As connected to the lift intervened and ask	on 10/2/23 at 2:41 p.m., NA-D itized lift and entered R31's 1 out of the chair and get R31 NA-D was getting R31 NA-D. The surveyor ed NA-D to step out of the d then asked to sanitize the				
	stated the lift was n	10/2/23 at 3:14 p.m., COTA-D ot sanitized before or after brior to putting it in the				
	stated the lift is sup	10/2/23 at 3:31 p.m., NA-D posed to be sanitized after ready for the next person that				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00865	B. WING		C 10/05/2023	
FRANCISCAN HEALTH CENTER 3910 MIN		3910 MINI	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE		
PREFIX (EACH DEF	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (ENCY)	ULD BE	(X5) COMPLETE DATE
21375 Continued Fr	om pa	ge 12	21375			
stated he did because the	not cl staff th d it. N	10/2/23 at 3: 36 p.m., NA-C ean the lift prior to use nat used it before NA-C should IA-C acknowledged he had not er he used it.				
infection previous should be satisfits were not would be an infection previous and cross contilinesses. The R37's chart a	ention nitized sanitized ncreas ntamir e IP re	on 10/4/23 at 2:02 p.m., the list (IP) stated all resident lifts at least after each use. If the zed after each use, there sed risk of spreading bacteria nation leading to resident viewed R18's, R31's and aftirmed none of the residents inicable diseases.				
director of nu was all staff of	rsing bserv	on 10/4/23 at 2:28 p.m. the (DON) stated their expectation e accurate infection controling lifts to protect all residents				
Equipment da	ated 3. oment	isinfection of Resident Care /22/17, identified durable would be cleaned and n residents.				
designee courrelated to equ	ld rev iiptme	of Correction: The DON or lew/revise facility policies nt sanitization, educate staff to ensure compliaince.				
Time Period to days.	or Co	rrection: Twenty-one (21)				
21535 MN Rule4658 Drug Usage;		Subp.1 ABCD Unnecessary	21535			11/20/23

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 13 of 20

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		` ′	X3) DATE SURVEY COMPLETED	
		00865	B. WING		10/0	5/2023	
	PROVIDER OR SUPPLIER SCAN HEALTH CENTI	3910 MINN	DRESS, CITY, S NESOTA AVI MN 55802	STATE, ZIP CODE ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21535	must be free from unnecessary drug is A. in excessive therapy; B. for excessive C. without adea D. in the preservice which indicate the adiscontinued. In addition to the discontinued.	al. A resident's drug regimen innecessary drugs. An sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply the Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, ing Administration, April 1992. Forporated by reference. It is the Minitex interlibrary loan the Law Library. It is not	21535				
	by: Based on observation review the facility fac	ent is not met as evidenced on, interview and document iled to implement effect monitoring for 1 of 2 ewed for anticoagulant use.		Corrected			
	9/27/23, identified description of peripheral vascular disease. R12 was anticoagulant was u	imum Data Set (MDS) dated liagnoses of hypertension and disease or peripheral arterial cognitively intact and an used during the last seven mpletion of the MDS.					

Minnesota Department of Health

STATE FORM 57E211 If continuation sheet 14 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00865	B. WING		C 10/05/2023
	PROVIDER OR SUPPLIER	ER 3910 MINI	DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21535	Continued From pa	ge 14	21535		
	directed staff to adrithinner that can only observation) 20 mill R12's care plan dat R12's interventions or that R12 was on During interview on assistant (NA)-A starefer to electronic mobody on NA-A's uthinner and needed reviewed R12's meassistants had access not on blood thinner During interview on registered nurse (R Xarelto based on the where else on the elindicated R12 was staff would be awar bleeding/bruising with thinner and needed and the staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff would be awar bleeding/bruising with the staff was a staff was a staff would be awar bleeding/bruising with the staff was a staff was a staff would be awar bleeding/bruising with the staff was a staff wa	ligrams (mg) daily. sed 5/25/22, failed to identify related to anticoagulant use anticoagulant. 10/5/23 at 11:13 a.m., nursing ated the nursing assistants nedical record to know how to be reach resident. There was unit that was on a blood closer monitoring. NA-A dical record that nurse ess to and indicated R12 was rs. 10/5/23 at 11:53 a.m., N)-A stated R12 was on the medication orders. No electronic medical record on blood thinners so no other record as needed. 10/5/23 at 11:59 a.m., the (DON) stated there should be			
	anticoagulant side of bruising. There should the care plan so all aware of the increase bruising. All staff we bleeding to keep the	effects such as bleeding and buld also be an intervention in staff that work with R12 are sed risk of bleeding and ere expected to monitor for e resident safe.			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00865	B. WING		10/0	5 5/2023
FRANCISCAN HEALTH CENTER			DRESS, CITY, S NESOTA AVE MN 55802	STATE, ZIP CODE ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	The DON or design revise policies to information for behaviors/side exintervention for schemedications; educations and then audit for compared to the policies to intervention for scheme audit for compared to the policies to intervention for scheme audit for compared to the policies to intervention for scheme audit for compared to the policies to intervention for scheme audit for compared to the policies to intervention for scheme audit for compared to the policies to intervention for scheme audit for scheme audit for compared to the policies to intervention for scheme audit for scheme audit for compared to the policies to intervention for scheme audit for scheme audit for scheme audit for compared to the policies and the policies and the policies are scheme audit for scheme aud	HOD OF CORRECTION: ee could develop and/or clude diagnoses, monitoring effects, non-pharmacological eduled and as needed te staff on the expectation and	21535			
21830	Residents of HC Fa Subd. 10. Particip notification of family (a) Residents shall in the planning of the includes the opport alternatives with inco opportunity to reque care conferences, a family member or of both. In the event to present, a family me chosen by the residences. (b) If a resident we unconscious or con- communicate, the faction of the faction of the faction of the either a family mem- writing by the residence and emergency that admitted to the faction of	ation in planning treatment;	21830			11/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE S COMPLE	TE SURVEY MPLETED	
	00865	B. WING		C 10/05	/2023	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FRANCISCAN HEALTH CENTI	FR	NESOTA AVE MN 55802	ENUE			
	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21830 Continued From pa	ge 16	21830				
to believe the resided directive to the continuency specified in writing a member included in notifying a family member to perforts, consistent with practice, to determine executed an advance sident's health care this paragraph, "readent's health care this paragraph, "readent's health care this paragraph, "readent's (2) examining the resident in the possion (3) inquiring of an family member considered whether the residered directive and whether the residered directive. If a facility designated emergency contact family member to participate accordance with the industrial member was patient's privacy rigus (c) In making readently member or defamily member or defamily member or defamily member or defamily shall atternembers or a designated emergency contact family member or defamily shall atternembers or a designated emergency contact family member or a designated emergency contact family member or defamily member or a designated emergency contact family member or defamily member or a designated emergency contact family membe	ent has an effective advance trary or knows the resident has that they do not want a family a treatment planning. After ember but prior to allowing a articipate in treatment which must make reasonable with reasonable medical ne if the resident has ce directive relative to the edecisions. For purposes of asonable efforts" include: expersonal effects of the ession of the facility; my emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for expersonal effects of the ession of the facility goes for the physician to whom the poes for care, if known, at has executed an advance ey notifies a family member or ncy contact or allows a family ate in treatment planning in sparagraph, the facility is not a damages on the grounds that the family member or or the participation of the simproper or violated the					

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		00865	B. WING		10/05	/2023
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENTE	ER	NESOTA AVE MN 55802	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	possession of the fato notify a family me emergency contact admission, the facility social service agency that the resist the facility has been member or designate county social service enforcement agency identifying and notificated emerge service agency or lot that assists a facility subdivision is not liad damages on the growthe family member participation of the for violated the patient or violated the patient or violated the patient facility failed to hone early morning toileting reviewed for choice reviewed for choice and the family member participation of the facility failed to hone early morning toileting facility failed to hone early morning toileting reviewed for choice and facility failed to hone early morning toileting facility failed to hone early morning failed facility failed to hone early morning failed facility failed to hone early morning failed facility failed f	cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and in unable to notify a family ted emergency contact. The e agency and local law y shall assist the facility in ying a family member or ney contact. A county social local law enforcement agency y in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper ent's privacy rights. The ent is not met as evidenced and document review, the or individual preferences for ng for 1 of 4 residents (R7) s. The family member was improper ent's privacy rights. The family member was improper ent's privacy rights.	21830	Corrected		
	R7's care plan date	d 8/17/23, directed staff to				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3910 MINNESOTA AVENUE		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
3910 MINNESOTA AVENUE			00865	B. WING		1	
FRANCISCAN HEALTH CENTER DULUTH, MN 55802			ER 3910 MINI	NESOTA AVE	·		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
check and change R7's brief at 5:00 a.m. R7 had a history of urinary tract infections. During an interview on 10/2/23 at 1:27 p.m., R7 stated they repeatedly biod staff they wanted staff to wake them up at 5:00 a.m., but it was not getting done. R7 shared this request with managers. If the night staff didn't get R7 up at 5:00 a.m. R7 usually had to wait until around 7:00 a.m. to get assistance to the bathroom. During an interview on 10/4/23 at 7:37 a.m., R7 reported they had woken up around 6:00 a.m. and had to call for staff to come in. R7 did not recall what time they got up on 10/3/23, but indicated no one woke R7 to use the bathroom at 5:00 a.m. During an interview on 10/5/23 at 1:34 a.m., R7 stated nobody woke them at 5:00 a m. and R7 had to call for staff assistance when they woke up. R7 explained they wanted staff to get them up at 5:00 a.m. because they didn't want to have an incontinence episode. They were not concerned about the actual incontinence but were afraid of getting a UTI from being in a wet brief while they waited their turn for help. During an interview on 10/5/23 at 1:54 a.m., registered nurse (RN)-B stated it was her expectation that staff would be getting R7 up at 5.00 a.m. each morning because that was R7's preference. R7's care plan was specifically updated to include a 5:00 a.m. wake time as that was R7's preference. During an interview on 10/5/23 at 2:07 p.m., the director of nursing (DON) stated if it was care planned for a resident to be woke up at 5:00 a.m., then they expected staff would be going in each		check and change is a history of urinary to stated they repeated to wake them up at getting done. R7 sh managers. If the night 5:00 a.m. R7 usuall a.m. to get assistant During an interview reported they had we and had to call for strecall what time the indicated no one we stated nobody woke had to call for staff up. R7 explained that 5:00 a.m. because incontinence episod about the actual incogetting a UTI from the waited their turn for During an interview registered nurse (Rexpectation that staff:00 a.m. each more preference. R7's caupdated to include a was R7's preference. During an interview director of nursing (planned for a reside of the planned	R7's brief at 5:00 a.m. R7 had tract infections. on 10/2/23 at 1:27 p.m., R7 dly told staff they wanted staff 5:00 a.m., but it was not hared this request with ght staff didn't get R7 up at ly had to wait until around 7:00 nee to the bathroom. on 10/4/23 at 7:37 a.m., R7 woken up around 6:00 a.m. staff to come in. R7 did not ey got up on 10/3/23, but oke R7 to use the bathroom at least the first of the staff to get them up see they didn't want to have an de. They were not concerned continence but were afraid of being in a wet brief while they help. on 10/5/23 at 1:54 a.m., ln)-B stated it was her aff would be getting R7 up at raing because that was R7's are plan was specifically a 5:00 a.m. wake time as that he. on 10/5/23 at 2:07 p.m., the (DON) stated if it was care lent to be woke up at 5:00 a.m.,				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00005	B. WING		C	
		00865	D. WING		10/05/2023	
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
FRANCIS	SCAN HEALTH CENTE	ER	NESOTA AVE MN 55802	ENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
21830	Continued From pa	ge 19	21830			
	_	n. to see if the resident wanted lest to be woken at 5:00 a.m.				
	dated 3/7/22, indicated develop an individual respected and identification when determining dated. The policy indicated	erson Centered Care Planning ted the care center would al plan of care which tified individualized choices laily care needs and activities. If the facility would honor long it was determined there ated with the choice.				
	social worker and/or/revise policies for real facility staff on the designee could contensure resident characters.	HOD OF CORRECTION: The resident choices and educate lose policies. The DON and/or duct resident interviews to lices are being honored, to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				