DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 19, 2021

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: May 19, 2021

Dear Administrator:

On June 11, 2021, we notified you a remedy was imposed. On July 14, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 1, 2021.

As authorized by CMS the remedy of:

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

However, as we notified you in our letter of June 7, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 1, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 7, 2021

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: May 3, 2021

Dear Administrator:

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

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 19, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 19, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245258	A. BUILDING _____ B. WING _____	C 05/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/17/21, through 5/19/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5258044C (MN72806), with deficiencies cited at F600, F609. H5258045C (MN72802), with a deficiency cited at F550. H5258046C (MN72797), with deficiencies cited at F550, F576, F690. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		6/27/21

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

Electronically Signed | 06/16/2021

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R2, R8) reviewed for dignity were provided proper clothing to wear. In addition, the facility failed to ensure dignity was provided with toilet use for 1 of 4	F 550	Resident Rights/Exercise of Rights The Administrator and Environmental Services Director will oversee all sections of this plan of correction, including the education, auditing and review of those	

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F 550	Continued From page 2 residents (R3) reviewed for toileting. Finding include: R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body). R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired. R2's MDS indicated he required an assist of one for dressing. R2's care plan initiated on 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily. On 5/17/21, at 2:35 p.m. R2's family member (FM)-D was interviewed and stated that R2 was made ready for bed on at least one occasion during his stay, wearing only an incontinence brief because he didn't have any clean clothes. FM-D also stated she was told the facility did not have any gowns available. FM-D stated she found R2 in tears, he was forced to sit in his own bowel movement. FM-D stated she would find R2 in bed wearing only an incontinent brief because he had no clean clothes, and the facility had no clean gowns. R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive. R8's quarterly MDS dated 3/24/21, indicated R8	F 550	materials. • R2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary. • All residents have potential to be impacted by this deficient practice. • The care center policy on Dignity was reviewed by the IDT and no updates needed. • Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents. • On 5/7/2021 Administrator placed linen order. • Facility par level reviewed for all linen and adjustments were made as needed. • Administrator educated Environmental Services Director on maintaining proper par levels. • Environmental Services Director will audit linen par levels weekly and Administrator will be auditing linen par levels monthly starting on 6/11/2021. • Linens will be ordered as needed. • Audit results will be brought to the QAPI committee quarterly for review and further recommendations. • Based on surveyor interviews and documentation review facility failed to ensure a bathroom was accessible to resident R3. • All residents within the facility could potentially be impacted by this practice. • R3 currently is not a resident within	

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F 550	Continued From page 3 was totally dependent on staff for dressing. R8's care plan initiated on 2/19/18, indicated R8 required assitance with dressing. R8's goal was to accept assistance with dressing and would be appropriately dressed daily. On 5/18/21, nursing assistant (NA)-E was interviewed. NA-E stated that R8 was put to bed wearing only an incontinent brief because she had no clean clothes. The facility did not have any gowns for her to wear. -at 12:44 NA-E was interviewed. NA-E stated she had observed residents in bed wearing only an incontinent brief because they didn't have clean clothes or clean gowns to put on them. NA-E stated she put R8 to bed wearing just an incontinent brief the night before because she could not find any clothing or a gown. NA-E stated the facility had been very short on linens, including gowns. -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated it was not dignified to leave a resident in only an incontinent brief if the resident's preference was to sleep in pajama's or a gown. R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke).	F 550	the facility. • Assessments will be completed of all residents that use tub/shower bathrooms to determine if the use of that bathroom is still appropriate by the Nurse Manager. Resident preferences will be reviewed. Adjustments to resident care plans will be completed as needed by the Nurse Manager. • All staff will be educated on Resident Dignity in SNF created by the American Health Care Association (AHCA) • Resident preferences will be discussed at residents quarterly care conference and as requested by the resident by the Social Services Director or designee. • Bathroom use/preference audits will be conducted 3x/week for 2 weeks and weekly thereafter to ensure resident preferences are met. • Results will be brought and reviewed to quarterly QAPI committee for further recommendations if needed.	

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F 550	Continued From page 4	F 550		

R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, was occasionally incontinent of urine and always continent of bowel. R3's MDS indicated she required extensive assistance with toileting and dressing.

On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower room bathrooms, and not being able to use the bathroom because the rooms were in use by other residents.

On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her shared room, her wheelchair was too wide to fit through the door. R3 stated she did not want to use a commode because they move during transfer and do not allow for privacy. R3 stated she was supposed to use the bathrooms in the tub/shower rooms, but the rooms were kept locked, the floors were frequently wet, and they were not available if another resident was using the room for bathing/showering. R3 stated this caused her to have accidents, and this would make her feel bad and she would sometimes cry.

-at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring an incontinent brief with her as there were no supplies in the shower and tub rooms.

-at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence

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F 550	Continued From page 5 episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms because the door was locked. On 5/19/21, at 10:28 a.m. the DON was interviewed and stated he was aware R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine. The DON stated this was a dignity issue for R3. -at 11:52 a.m. the administrator was interviewed. The administrator stated it was a dignity issue when someone who was continent of bladder was incontinent because they could not get to a bathroom in time. The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication system.	F 550		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the	F 576		6/27/21

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F 576	Continued From page 6 facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility. Findings include: On 5/18/21, at 12:54 p.m. activities aide (AA)-A was interviewed. AA-A stated on the weekend, mail would be placed in the conference room, and	F 576	Right to forms of communication with privacy The Administrator and Activities Director will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • SW-A and AA-A were educated on delivering resident mail on Saturdays. • All residents within the facility could potentially be impacted by this practice.	

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F 576	Continued From page 7 would remain there until Monday. AA-A stated the activities director or the social worker would then go through the mail, and determine what mail should be delivered to residents. AA-A stated this was done to ensure residents didn't throw out any important mail. On 5/19/21, at 9:56 a.m. the social worker (SW)-A was interviewed. SW-A verified mail was not delivered to residents on Saturdays. SW-A stated this was to ensure mail that was supposed to be be forwarded to families was not delivered to residents and accidentally thrown away. SW-A stated this was a violation of rights. -at 10:20 a.m. the director of nursing (DON) was interviewed. The DON was not aware residents were not receiving mail on Saturday. The DON stated this was a violation of resident rights. -at 11:52 a.m. the administrator was interviewed. The administrator was not aware mail was not being delivered on Saturdays. The administrator stated this was a violation of resident rights. A policy on receiving mail was requested, but not provided.	F 576	• Upon admission resident is asked how they would like their mail to be handled. Choices are: 1. Receive all mail. 2. Receive personal mail only; business mail to responsible party. 3. Activities to read personal mail; business mail to be read by responsible party. 4. All mail goes to responsible party. • On 5/19/2021 Administrator educated Activities Director regarding mail procedure. • All Activities staff educated as to preference for mail delivery and procedure, including mail delivery on Saturdays. • Activity Director will conduct random audits on Monday's to ensure mail was passed out per procedure and preferences starting on 5/24/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		6/27/21

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F 584	Continued From page 8 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident clothing was laundered and available for 2 of 4 residents (R2, R8) reviewed for linen use. In addition, the facility failed to ensure facility gowns were available.	F 584	Safe/Clean/Comfortable/Homelike Environment The Administrator and Environmental Services Director will oversee all sections of this plan of correction, including the education, auditing and review of those	

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	245258	A. BUILDING _____ B. WING _____	C 05/19/2021

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F 584	Continued From page 9 Findings include: R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body). R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing. R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily. R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive. R8's quarterly MDS dated 3/24/21, indicated R8 was totally dependent on staff for dressing. R8's care plan dated 2/19/18, indicated R8 required assistance with dressing. The goal on 2/14/20, was R8 would be appropriately dressed daily. On 5/17/21, at 2:35 p.m. family member (FM)-D was interviewed. FM-D stated the facility staff would leave R2 lying in bed with only his incontinence brief on because he had no clean clothes. -at 12:44 nursing assistant (NA)-E was interviewed. NA-E stated she had observed residents in bed wearing just an incontinent brief	F 584	materials. • R2 is no longer a resident at the care center. The Administrator and Environmental Services Director reviewed the inventory of linens available for R8. Personal laundry inventory reviewed for R8 and was provided more laundry as necessary. • All residents have potential to be impacted by this deficient practice. • The care center policy on Dignity was reviewed by the IDT and no updates needed. • Administrator and Environmental Services Director reviewed inventory of house-wide linens for all residents. • On 5/7/2021 Administrator placed linen order. • Facility par level reviewed for all linen and adjustments were made as needed. • Administrator educated Environmental Services Director on maintaining proper par levels. • Environmental Services Director will audit linen par levels weekly and Administrator will be auditing linen par levels monthly starting on 6/11/2021. • Linens will be ordered as needed. • Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	

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F 584	Continued From page 10 because they didn't have clothes or gowns to put on them. NA-E stated she had put R8 to bed wearing just a brief the night before because she could not find any of their clothing or a facility gown. NA-E stated the facility had been very short on linens, including facility gowns. -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated he had been aware for two to three weeks that staff were saying there was not enough linen. -at 11:52 a.m. the administrator was interviewed. The administrator stated she had been aware for the past two weeks that staff were saying there was not enough linen.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		6/27/21

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F 600	Continued From page 11 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse related to an allegation of staff to resident abuse for 1 of 4 reviewed for abuse. Findings include: R1's Disease Diagnosis & Allergies list printed on 5/19/21, indicated R1 had diagnoses which included unspecified dementia without behavioral disturbance. R1's quarterly Minimum Data Set (MDS) dated 3/31/21, indicated R1 was severely cognitively impaired, and was able to eat independently. R1's care plan dated 3/31/21, indicated staff was to provide set up assist and cues with meals as needed. A report submitted to the State Agency (SA) on 5/12/21, indicated registered nurse (RN)-B was observed sometime in March or April of 2021, forcing R1 to drink juice. The report indicated they heard RN-B say R1 needed to drink, and if she couldn't drink, RN-A would make sure she drank. RN-B was observed holding R1's mouth forcing it open, and forcing the juice down R1's throat. It was reported R1 screamed, choked, and lashed out with her arms. The reporter stated she told staff present about the incident. On 5/18/21, at 2:14 p.m. RN-B was interviewed. RN-B stated she has had to push fluids with R1, and stated she had put her hand on the back of R1's head and forced her to drink.	F 600	Free from Abuse and Neglect The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • Based on interviews, documentation reviewed by surveyor and report submitted to state agency RN-B was observed sometime in March or April of 2021 forcing resident R-1 to drink juice. • All residents within the facility could potentially be impacted by this practice. • Resident interviews were completed by social services director asking if they had ever been forced “to take medications, food or liquids against their will”. All residents expressed that this had never happened to them and expressed no further concerns. • IDT reviewed Maltreatment Prohibition Policy with no changes noted. • On 5/20/2021 1:1 Education provide to staff member RN-B on the maltreatment prohibitions policy and assisting resident with taking oral medications, food and liquids and honoring resident wishes when refusing those services by Director of Nursing. • On 5/19/2021 House wide Licensed Nursing education provided on the proper assistance when offering residents medications, food and liquids. • Audits will be performed on the proper administration of medications, food and liquids and process to be used by nurses then the resident refuses those items	

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F 600	Continued From page 12 On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated it would be physical abuse if a staff member prevented a resident from moving their head and forced them to drink fluids. -at 11:52 a.m. the administrator was interviewed. The administrator stated it would be abuse if a staff member prevented a resident from moving their head and forced them to drink fluids. The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.	F 600	2x/week X4 weeks and then 2X/month X 2 months starting on 5/20/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		6/27/21

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F 609	Continued From page 13 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse for 1 of 4 residents (R1) reviewed for abuse. Findings include: R1's Disease Diagnosis & Allergies list printed 5/19/21, indicated R1 had diagnoses which included unspecified dementia without behavioral disturbance. R1's quarterly Minimum Data Set (MDS) dated 3/31/21, indicated R1 was severely cognitively impaired, and was able to eat independently. R1's care plan dated 3/31/21, indicated staff was to provide set up assist and cues with meals as needed. A report submitted to the State Agency (SA) on 5/12/21, indicated registered nurse (RN)-B was observed sometime in March or April of 2021, forcing R1 to drink juice. The report indicated they heard RN-B say R1 needed to drink, and if she couldn't drink, RN-A would make sure she drank. RN-B was observed holding R1's mouth forcing it open, and forcing the juice down R1's throat. It	F 609	Reporting of Alleged Violations The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • R1 abuse allegation was reported on 5/19/2021 to the State Agency (SA). Tracking ID #342025 • All residents within the facility could potentially be impacted by this practice. • All allegations of abuse will be reported timely to the Administrator. Facility will report timely and report according to facility policy and state and federal guidelines. • Maltreatment Reporting Guidelines policy was reviewed by the Social Services Director, Director of Nursing and Administrator regarding reporting of allegations of abuse. • All staff have been educated on the Maltreatment Reporting Guidelines policy by the Administrator or designee, regarding reporting immediately to the Administrator any alleged abuse. • Audits will be completed on a continuous bases. Social Services	

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F 609	Continued From page 14 was reported R1 screamed, choked, and lashed out with her arms. The reporter stated she told staff present about the incident. On 5/18/21, at 2:14 p.m. registered nurse (RN)-B was interviewed. RN-B stated she has had to push fluids with R1, she puts her hand on the back of her head and forced her to drink. On 5/18/21, at 2:14 p.m. RN-B was interviewed. RN-B stated she has had to push fluids with R1, and stated she had put her hand on the back of R1's head and forced her to drink. The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy directed staff to report immediately as soon as possible, but not later than two hours after the allegation is made.	F 609	Director will review copies of concern forms and reporting checklist with Administrator. Administrator will review all documentation for potential abuse and neglect and timely reporting to SA. • Administrator will audit all alleged abuse complaints to ensure that they have been reported timely to the SA on an on-going basis starting on 5/19/2021. • All audit results will be brought and reviewed with quarterly QAPI committee for further recommendations.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		6/27/21

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F 690	Continued From page 15 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a bathroom was accessible to prevent incontinence for 1 of 4 residents (R3) reviewed for bladder incontinence. Finding include: R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke) of left mid cerebral artery. R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, and required extensive	F 690	Bowel/Bladder Incontinence, Catheter, UTI The Administrator and Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. • Based on surveyor interviews and documentation review facility failed to ensure a bathroom was accessible to resident R3. • All residents within the facility could potentially be impacted by this practice. • R3 currently is not a resident within the facility. • Assessments will be completed of all	

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F 690	Continued From page 16 assistance with transfers and toilet use. R3's MDS further indicated she was occasionally incontinent of bladder. R3's care plan dated 2/8/21, indicated R3's goal was to not decline in bladder continence. The care plan directed staff to encourage fluid intake, and offer assistance to toilet every two to three hours and as needed. On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower bathrooms. R3 was sometimes not able to use the bathroom because other residents were bathing or showering. On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her room, her wheelchair was too wide. The facility's solution was for her to use a commode in her room. R3 did not find this a satisfactory solution, not enough privacy and the commodes have potential to slide during transfers. The facility said she could use the bathrooms in the shower room or the bathroom in the tub room. R3 stated the rooms were frequently in use for showers or baths, and the floors were often wet. R3 stated the rooms were kept locked when not in use, the key not accessible for a person in a wheelchair, and the doors were alarmed if someone tried to open the door without a key. R3 stated if she could not get there in time she would have an accident. On 5/18/21, at 7:17 a.m. registered nurse (RN)-A was interviewed. RN-A stated it R3's wheelchair did not fit into the bathroom, she stated it was part of R3's therapy to be able to get herself to and from the bathroom to discharge to her home	F 690	residents that use tub/shower bathrooms to determine if the use of that bathroom is still appropriate by the Nurse Manager. Resident preferences will be reviewed. Adjustments to resident care plans will be completed as needed by the Nurse Manager. • All staff will be educated on Resident Dignity in SNF created by the American Health Care Association (AHCA) • Resident preferences will be discussed at residents quarterly care conference and as requested by the resident by the Social Services Director or designee. • Bathroom use/preference audits will be conducted 3x/week for 2 weeks and weekly thereafter to ensure resident preferences are met. • Results will be brought and reviewed to quarterly QAPI committee for further recommendations if needed.	

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F 690	Continued From page 17	F 690		

safely.

-at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring a brief with her as there were no supplies in the shower and tub rooms.

-at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms because the door was locked.

On 5/19/21, -at 10:28 a.m. the director of nursing (DON) was interviewed. The DON was aware that R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine.

-at 2:14 p.m. RN-B was interviewed. RN-B stated she was aware that R3 was incontinent of urine because she couldn't get into the bathroom on time.

The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication system.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 7, 2021

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: VVZL11

Dear Administrator:

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

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/17/21, through 5/19/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 05/19/2021

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2 000	Continued From page 1 The following complaint were found to be SUBSTANTIATED: H5258044C (MN72806) with a licensing order issued at 626.557 Subd 3 H5258045C (MN72802) with a licensing order issued at 144.651 Subd 14 H5258046C (MN72797) with a licensing order issued at 144.651 Subd 14, 4658.0520 Subp 2 A, 4658.1405 A B C D Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 385	MN Rule 4658.0200 Subp. 3 Policies Concerning Residents; Mail Subp. 3. Mail. A resident must receive mail unopened unless the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident has requested in writing that the mail be reviewed. The outgoing mail must not be censored. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility. Findings include: On 5/18/21, at 12:54 p.m. activities aide (AA)-A was interviewed. AA-A stated on the weekend, mail would be placed in the conference room, and would remain there until Monday. AA-A stated the activities director or the social worker would then go through the mail, and determine what mail should be delivered to residents. AA-A stated this was done to ensure residents didn't throw out any important mail. On 5/19/21, at 9:56 a.m. the social worker	2 385	Corrected	6/27/21

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2 385	Continued From page 3 (SW)-A was interviewed. SW-A verified mail was not delivered to residents on Saturdays. SW-A stated this was to ensure mail that was supposed to be be forwarded to families was not delivered to residents and accidentally thrown away. SW-A stated this was a violation of rights. -at 10:20 a.m. the director of nursing (DON) was interviewed. The DON was not aware residents were not receiving mail on Saturday. The DON stated this was a violation of resident rights. -at 11:52 a.m. the administrator was interviewed. The administrator was not aware mail was not being delivered on Saturdays. The administrator stated this was a violation of resident rights. A policy on receiving mail was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are receiving their mail on Saturdays. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 385		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and	2 835		6/27/21

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2 835	Continued From page 4 proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a bathroom was accessible to prevent incontinence for 1 of 4 residents (R3) reviewed for bladder incontinence. Finding include: R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke) of left mid cerebral artery. R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, and required extensive assistance with transfers and toilet use. R3's MDS further indicated she was occasionally incontinent of bladder. R3's care plan dated 2/8/21, indicated R3's goal was to not decline in bladder continence. The care plan directed staff to encourage fluid intake, and offer assistance to toilet every two to three hours and as needed. On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower bathrooms. R3 was sometimes not able to use the bathroom because other residents were bathing or showering.	2 835	Corrected	

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2 835	Continued From page 5 On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her room, her wheelchair was too wide. The facility's solution was for her to use a commode in her room. R3 did not find this a satisfactory solution, not enough privacy and the commodes have potential to slide during transfers. The facility said she could use the bathrooms in the shower room or the bathroom in the tub room. R3 stated the rooms were frequently in use for showers or baths, and the floors were often wet. R3 stated the rooms were kept locked when not in use, the key not accessible for a person in a wheelchair, and the doors were alarmed if someone tried to open the door without a key. R3 stated if she could not get there in time she would have an accident. On 5/18/21, at 7:17 a.m. registered nurse (RN)-A was interviewed. RN-A stated it R3's wheelchair did not fit into the bathroom, she stated it was part of R3's therapy to be able to get herself to and from the bathroom to discharge to her home safely. -at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring a brief with her as there were no supplies in the shower and tub rooms. -at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms	2 835		

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2 835	Continued From page 6 because the door was locked. On 5/19/21, -at 10:28 a.m. the director of nursing (DON) was interviewed. The DON was aware that R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine. -at 2:14 p.m. RN-B was interviewed. RN-B stated she was aware that R3 was incontinent of urine because she couldn't get into the bathroom on time. The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication system. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents have ready access to bathroom facilities to prevent incontinence. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		

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21670	Continued From page 7	21670		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident clothing was laundered and available for 2 of 4 residents (R2, R8) reviewed for linen use. In addition, the facility failed to ensure facility gowns were available. Findings include: R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to	21670	Corrected	6/27/21

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21670	Continued From page 8	21670		

understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body).

R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired, and required assistance with dressing.

R2's care plan dated 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be appropriately dressed daily.

R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive.

R8's quarterly MDS dated 3/24/21, indicated R8 was totally dependent on staff for dressing.

R8's care plan dated 2/19/18, indicated R8 required assistance with dressing. The goal on 2/14/20, was R8 would be appropriately dressed daily.

On 5/17/21, at 2:35 p.m. family member (FM)-D was interviewed. FM-D stated the facility staff would leave R2 lying in bed with only his incontinence brief on because he had no clean clothes.

-at 12:44 nursing assistant (NA)-E was interviewed. NA-E stated she had observed residents in bed wearing just an incontinent brief because they didn't have clothes or gowns to put on them. NA-E stated she had put R8 to bed wearing just a brief the night before because she could not find any of their clothing or a facility gown. NA-E stated the facility had been very short on linens, including facility gowns.

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21670	Continued From page 9 -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated he had been aware for two to three weeks that staff were saying there was not enough linen. -at 11:52 a.m. the administrator was interviewed. The administrator stated she had been aware for the past two weeks that staff were saying there was not enough linen. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents laundry is returned to them timely and ensure there is enough linen available for use. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21670		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in	21850		6/27/21

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21850	Continued From page 10 section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R2, R8) reviewed for dignity were provided proper clothing to wear. In addition, the facility failed to ensure dignity was provided with toilet use for 1 of 4 residents (R3) reviewed for toileting. Finding include: R2's Face Sheet printed on 5/19/21, indicated R2's diagnoses included cerebrovascular accident (stroke), aphasia (loss of the ability to understand or express speech), and hemiplegia and hemiparesis (paralysis of one side of the body). R2's admission Minimum Data Set (MDS) dated 3/17/21, indicated R2 was severely cognitively impaired. R2's MDS indicated he required an assist of one for dressing. R2's care plan initiated on 3/15/21, indicated R2 needed assistance with dressing. R2's goals were to participate in dressing and he would be	21850	Corrected	

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21850	Continued From page 11 appropriately dressed daily. On 5/17/21, at 2:35 p.m. R2's family member (FM)-D was interviewed and stated that R2 was made ready for bed on at least one occasion during his stay, wearing only an incontinence brief because he didn't have any clean clothes. FM-D also stated she was told the facility did not have any gowns available. FM-D stated she found R2 in tears, he was forced to sit in his own bowel movement. FM-D stated she would find R2 in bed wearing only an incontinent brief because he had no clean clothes, and the facility had no clean gowns. R8's Face Sheet printed on 5/19/21, indicated R8's diagnoses included mild cognitive impairment, and adult failure to thrive. R8's quarterly MDS dated 3/24/21, indicated R8 was totally dependent on staff for dressing. R8's care plan initiated on 2/19/18, indicated R8 required assitance with dressing. R8's goal was to accept assistance with dressing and would be appropriately dressed daily. On 5/18/21, nursing assistant (NA)-E was interviewed. NA-E stated that R8 was put to bed wearing only an incontinent brief because she had no clean clothes. The facility did not have any gowns for her to wear. -at 12:44 NA-E was interviewed. NA-E stated she had observed residents in bed wearing only an incontinent brief because they didn't have clean clothes or clean gowns to put on them. NA-E stated she put R8 to bed wearing just an incontinent brief the night before because she could not find any clothing or a gown. NA-E	21850		

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21850	Continued From page 12 stated the facility had been very short on linens, including gowns. -at 1:43 p.m. environmental service (ES)-C was interviewed. ES-C stated laundry was done at an outside facility with deliveries on Monday, Wednesday, and Friday. On 5/19/21, at 10:28 a.m. the director of nursing (DON) was interviewed. The DON stated it was not dignified to leave a resident in only an incontinent brief if the resident's preference was to sleep in pajama's or a gown. R3's Face Sheet printed 5/19/21, indicated R3's diagnoses included spastic hemiplegia (muscles on one side of the body in a constant state of contraction) affecting left non-dominant side, and cerebral infarction (stroke). R3's admission MDS dated 2/15/21, indicated R3 was cognitively intact, was occasionally incontinent of urine and always continent of bowel. R3's MDS indicated she required extensive assistance with toileting and dressing. On 4/24/21, at 4:48 a.m. a progress note indicated R3 was upset about the difficulty in using the tub/shower room bathrooms, and not being able to use the bathroom because the rooms were in use by other residents. On 5/17/21, at 2:35 p.m. R3 was interviewed. R3 stated she was not able to use the bathroom in her shared room, her wheelchair was too wide to fit through the door. R3 stated she did not want to use a commode because they move during transfer and do not allow for privacy. R3 stated she was supposed to use the bathrooms in the tub/shower rooms, but the rooms were kept	21850		

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21850	Continued From page 13	21850		

locked, the floors were frequently wet, and they were not available if another resident was using the room for bathing/showering. R3 stated this caused her to have accidents, and this would make her feel bad and she would sometimes cry.

-at 12:26 p.m. NA-B was interviewed. NA-B stated R3's wheelchair would not fit through the bathroom door. NA-B stated it would take R3 about 10 minutes to wheel herself to the shower or tub room. NA-B stated the door was locked, it would alarmed if she tried to open it, and if she had an accident she would need to bring an incontinent brief with her as there were no supplies in the shower and tub rooms.

-at 12:44 NA-E was interviewed. NA-E stated she witnessed R3 have bladder incontinence episodes on "multiple" occasions because she couldn't get into the shower/tub bathrooms because the door was locked.

On 5/19/21, at 10:28 a.m. the DON was interviewed and stated he was aware R3 could not always get to the shower/tub room bathroom in time to prevent being incontinent of urine. The DON stated this was a dignity issue for R3.

-at 11:52 a.m. the administrator was interviewed. The administrator stated it was a dignity issue when someone who was continent of bladder was incontinent because they could not get to a bathroom in time.

The facility document Best Practices For Compliance Related to Resident Dignity In Skilled Nursing Facilities created by The American Health Care Association undated, directed staff to maintain or improve his or her abilities to bathe, dress, and groom; transfer and ambulate; toilet;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00865	A. BUILDING: _____ B. WING _____	C 05/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 14 eat; and use speech, language, or other functional communication system. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are properly clothed in bed (not just in a brief) and residents who are continent do not have episodes of incontinence. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the	21980		6/27/21

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21980	Continued From page 15 previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse for 1 of 4 residents (R1) reviewed for abuse. Findings include:	21980	Corrected	

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21980	Continued From page 16 R1's Disease Diagnosis & Allergies list printed 5/19/21, indicated R1 had diagnoses which included unspecified dementia without behavioral disturbance. R1's quarterly Minimum Data Set (MDS) dated 3/31/21, indicated R1 was severely cognitively impaired, and was able to eat independently. R1's care plan dated 3/31/21, indicated staff was to provide set up assist and cues with meals as needed. A report submitted to the State Agency (SA) on 5/12/21, indicated registered nurse (RN)-B was observed sometime in March or April of 2021, forcing R1 to drink juice. The report indicated they heard RN-B say R1 needed to drink, and if she couldn't drink, RN-A would make sure she drank. RN-B was observed holding R1's mouth forcing it open, and forcing the juice down R1's throat. It was reported R1 screamed, choked, and lashed out with her arms. The reporter stated she told staff present about the incident. On 5/18/21, at 2:14 p.m. registered nurse (RN)-B was interviewed. RN-B stated she has had to push fluids with R1, she puts her hand on the back of her head and forced her to drink. On 5/18/21, at 2:14 p.m. RN-B was interviewed. RN-B stated she has had to push fluids with R1, and stated she had put her hand on the back of R1's head and forced her to drink. The facility policy Maltreatment Prohibition reviewed/amended 2/19/18, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with	21980		

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21980	Continued From page 17 resulting physical harm, pain, or mental anguish. The policy directed staff to report immediately as soon as possible, but not later than two hours after the allegation is made. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure allegations of abuse are reported immediately. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		