DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 7, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: September 19, 2022

Dear Administrator:

On October 12, 2022, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

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Electronically delivered

November 7, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: Reinspection Results
Event ID: C40W12

Dear Administrator:

On October 12, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 19, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

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Electronically delivered
September 23, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

RE: CCN: 245258
Cycle Start Date: September 19, 2022

Dear Administrator:

On September 19, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 December 19, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 19, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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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 09/19/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/15/22, 9/16/22, and 9/19/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H54584541C (MN86507) H54584457C (MN86414) H54584457C (MN86433) The following complaint was found to be SUBSTANTIATED: H52584449C (MN86541) with deficiencies cited at F760. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (R1) reviewed for medication errors. R1 did not receive her insulin as prescribed by the physician of which resulted in blood glucose levels up to	F 760	F760 Residents are free of significant medication errors CRF(s): 483.45 (f)(2) The Administrator and/or Director of Nursing will oversee all sections of this	10/24/22

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

Electronically Signed | 10/03/2022

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

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F 760	Continued From page 1 600 mg/dl (Milligrams per deciliter; a unit of measure that shows the concentration of a substance in a specific amount of fluid. In the United States, blood glucose test results are reported as mg/dL). Findings include: R1's Face Sheet printed 9/19/22, indicated R1's diagnoses included type 1 diabetes with ketoacidosis (a serious complication of diabetes that can be life-threatening), dementia with behavioral disturbance, mild cognitive impairment and anxiety. R1's Minimum Data Set (MDS) dated 7/27/22, indicated R1 had severely impaired cognition. R1 did not have any behaviors and did not reject cares. R1 received insulin injections. The physician Order review as of 9/19/22, included the following orders: - Humalog 3 units (u) subcutaneous (sq) two times day after lunch (12:30 p.m.-2:30 p.m.) and after dinner 5:30 p.m.-7:30 p.m. With a start date of 6/7/22, for diabetes due to underlying condition with ketoacidosis without coma. Special instructions included do not give if resident does not have a snack. - Humalog insulin per sliding scale sq every day at bedtime between 7:00 p.m. and 10:00 p.m. with a start date of 6/7/22, for diabetes due to underlying condition with ketoacidosis without coma. Special instructions for blood glucose of 200-249 give 2 u, 250-299 give 4u, 300-350 give 6u, greater than 350 give 8u.	F 760	plan of correction, including the education, auditing and review of those materials. On 9/2/22 PM shift R1 should have received scheduled 3 units Humalog SQ and sliding scale 10 units Humalog SQ from PM Nurse as ordered by the provider. NOC nurse administered the 10 units SQ Humalog after review of resident blood sugars with the provider. All residents have potential to be impacted by this deficient practice. All resident insulin orders and EMR insulin administration accuracy reviewed. Insulin order times adjusted in EMR with R1 to clarify insulin instructions to nursing staff. All other insulin orders found to be clear and concise. EMR (Yardi) system reviewed and found to have a large amount of information listed for the nurse that does not need to be address during their specific shift. This may limit their ability to process that information and identify potential medication errors before they occur. FHC working with Yardi technician's to eliminate unneeded information or clutter shown on the EMR. With R1's complex insulin orders/routine/snack intake a review of the 24 hour nurse to nurse form was reviewed and adjusted to reflect R1's specific insulin needs and timing. All licensed nursing staff educated and sent a Ymail (internal communication system) reflecting the proper administration/charting of insulin and administering insulin as ordered by the provider. Message also reflected the change in the 24 hour form to better track	

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F 760	Continued From page 2 - Humalog insulin 10u sq one time a day at 10:30 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Humalog insulin 7u sq one time a day at 4:30 p.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Humalog insulin 12u sq one time a day at 7:30 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Humalog insulin per sliding scale sq before meals between 6:30 a.m.-9:00 a.m., 10:00 a.m.-12:00 p.m., 3:00 p.m.-5:00 p.m. With a start date of 6/7/22, for diabetes with hyperglycemia. Special instructions for blood glucose of 150-199 give 3u, 200-249 give 6u, 250-299 give 9u, 300-350 give 12u, greater than 350 give 15u. - Tresiba (a long acting insulin) 25u sq every day between 7:00 a.m.-11:00 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Notify the doctor if blood sugars are less than 70 for two times or greater than 450 for two times. - During each of the three shifts every day give small dose Novolog with smaller meals and higher dose with bigger meals or extra cookies. With a start date of 6/7/22. Between 6:30 a.m. 2:30 p.m. on the day shift. Between 2:30 p.m. - 10:30 p.m. on the evening shift and between 10:30 p.m. - 6:30 a.m. on the night shift. - Accucheck (blood glucose check) every day at 2:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. With a start date of 6/7/22.	F 760	R1 insulin administration. Audits will be performed by DON/designee 3X/week for 4 weeks, 2X/ week for 2 weeks then monthly. Monitoring will be reported to the next QA&A and as needed. Committee will monitor and make ongoing recommendations as needed.	

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F 760	Continued From page 3 A medication error report dated 9/2/22, indicated registered nurse (RN)-B notified registered nurse (RN)-A that R1's blood glucose was at 547 at 8:00 p.m. and then R1's blood glucose rose to 589 by bedtime. RN-A asked RN-B if R1's insulin was given. RN-B stated it was given but did not clarify if R1's bedtime insulin had been administered. RN-B contacted the on-call provider. RN-A spoke with the on call triage nurse returning the call. The triage nurse gave orders to send R1 to the emergency room (ER) but wanted to confirm with the provider first. RN-A reviewed R1's medical record and noticed R1's insulin was not administered after dinner or at bedtime. R1 had only received insulin prior to dinner. RN-A checked R1's blood glucose and it had increased to 600. RN-A administered R1's insulin late at 11:00 p.m. and notified the triage nurse of the error. R1 refused to be sent to the ER. RN-A explained to R1 the complications and risks associated with declining to go into ER. R1 was negative for Kussmaul respirations (fast, deep breaths that occur in response to metabolic acidosis. Kussmaul respirations happen when the body tries to remove carbon dioxide, an acid, from the body by quickly breathing it out. Diabetic ketoacidosis is the most common cause of Kussmaul respirations). R1's vital signs were stable and was alert and orientated at baseline. R1's provider called to ask why R1 was not at the ER. RN-A reported R1 had refused and informed the physician R1's blood glucose was now at 381. (Normal blood glucose two hours after a meal for a person without diabetes is less than 140. Official American Diabetes Association's recommended blood glucose two hours after a meal for someone with diabetes is less than 180.)	F 760		

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F 760	Continued From page 4 Progress note dated 9/3/22, at 7:45 a.m. written by RN-A indicated R1's daughter was notified of the elevated blood glucose and late administered insulin. R1's daughter expressed she was upset and frustrated because it was the second time that week R1 had missed her insulin. Progress notes dated 9/3/22, at 7:54 a.m. written by RN-A indicated the on call physician was contacted to follow up and request recommended orders. The physician ordered a one time dose of 28u of Tresiba instead of the normal dose of 25u. During an interview on 9/19/22, at 12:22 p.m. with R1's family member (FM). FM stated she was informed of R1's elevated blood sugars and the missed insulins early the next morning. FM stated this had also happened earlier in the week, due to the facility using travel nurses. FM stated R1 was able to make her own decision to go or not to go to the hospital. FM would respect R1's choice and knows R1 would not want to go to the hospital. R1 was not compliant with her diet. FM further stated she liked the facility. She had good communication, they don't make excuses and don't sweep things under the rug. During an interview on 9/19/22, at 12:59 p.m. RN-C stated on 8/31/22, R1 did not receive dinner time insulin. The nurse practitioner was notified and did not give new orders, R1's blood glucose was not elevated more than usual. RN-C stated the only way to know if a medication was not given was when the following nurse reviewed the electronic medication administration record (EMAR). The nurses catch missed medications and complete an incident report. R1 did not have a negative outcome. R1 was noncompliant with her diet and had a signed informed consent on	F 760		

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F 760	Continued From page 5 file. RN-C further stated R1 had dementia and if she ate something that would raise her blood sugar she would not remember or make the right food choices. During an interview on 9/19/22, at 2:49 p.m. RN-A stated RN-B came to her for physician's telephone number. RN-B reported to RN-A R1's blood glucose was 540 and 580. RN-A asked RN-B if she gave R1 her insulin. RN-B said yes. RN-A then took the return call from triage. Triage recommended sending R1 to the ER. R1 refused to go to the ER. R1's blood glucose was then 600. RN-A checked the EMAR. R1's EMAR indicated R1 had received her before dinner insulin but had not received her dinner or bedtime insulin. At 11:00 p.m. RN-A gave R1 the bedtime sliding scale insulin. R1's blood glucose went down to 381 in about one and a half hours. RN-A further stated, she knows R1 well and what to do when R1's blood glucose is low or high and being R1 refused to go into ER RN-A gave R1 her bedtime sliding scale insulin. RN-A stated two missed dosed of insulin could have killed R1. RN-A assessed R1 through the night. In the morning R1's blood glucose was 250. RN-A stated the current EMAR system does not show medications that are flagged or missed. The previous system would tell you when and what was due. During an interview on 9/19/22, at 4:54 p.m. with the administrator. The administrator stated staff were trained on watching for medication errors. The EMAR showed medications that were not signed off. The system showed if a medication was missed. The director of nursing (DON) reviewed the insulins. The system also stated why the medication was missed and the reason	F 760		

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F 760	Continued From page 6 the medication was not given was reviewed. The facility had a weekly meeting with the medical record software company and the administrator would bring the issue to the next meeting. On 9/20/22, at 1:43 p.m. RN-B was interviewed. RN-B stated she was an agency nurse, had worked at the facility for approximately two months. RN-B had worked at the facility on the afternoon shift for approximately 10 times. RN-B worked on the unit of which R1 resides every time except one. RN-B stated she was familiar with R1 and was aware R1 had high blood sugars but they usually went down. This was the first time RN-B had to call a physician regarding R1's blood sugars. RN-B stated on 9/2/22, she thought she had given and charted all of R1's insulins. RN-B was not aware R1 did not receive her insulin as ordered. RN-B had not received a call back from the physician. RN-B reported this to RN-A of which RN-A told her she could leave as her shift was done. RN-A stated the EMAR system had a flag that indicated you missed a medication. RN-B did not look back to see if any medications were flagged and d id not realize R1's insulins were not charted. RN-B further stated she thought she had given the insulins. RN-B returned to work at the facility the next day on 9/3/22, and no one said anything about R1 not receiving the insulins. The facility's Medication Administration/Error policy dated 4/6/15, indicated it was the intention of the facility to keep residents free from significant medication errors. Significant medication error means one which causes the resident discomfort or jeopardizes the residents' health safety. All medications need to be administered are prescribed.	F 760		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 23, 2022

Administrator
Franciscan Health Center
3910 Minnesota Avenue
Duluth, MN 55802

Re: State Nursing Home Licensing Orders
Event ID: C40W11

Dear Administrator:

The above facility was surveyed on September 15, 2022 through September 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

Sarah Lane

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

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 09/19/2022

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

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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 9/15/22, 9/16/22, and 9/19/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H54584541C (MN86507) H54584457C (MN86414) H54584457C (MN86433) The following complaints were found to be SUBSTANTIATED: H52584449C (MN86541) with licensing orders issued at 1545. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or	21545		10/24/22

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21545	Continued From page 2 safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (R1) reviewed for medication errors. R1 did not receive her insulin as prescribed by the physician of which resulted in blood glucose levels up to 600 mg/dl (Milligrams per deciliter; a unit of measure that shows the concentration of a substance in a specific amount of fluid. In the United States, blood glucose test results are reported as mg/dL).	21545	F760 and 1545 Residents are free of significant medication errors CRF(s): 483.45 (f)(2) The Administrator and/or Director of Nursing will oversee all sections of this plan of correction, including the education, auditing and review of those materials. On 9/2/22 PM shift R1 should have received scheduled 3 units Humalog SQ and sliding scale 10 units Humalog SQ	

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21545	Continued From page 3 Findings include: R1's Face Sheet printed 9/19/22, indicated R1's diagnoses included type 1 diabetes with ketoacidosis (a serious complication of diabetes that can be life-threatening), dementia with behavioral disturbance, mild cognitive impairment and anxiety. R1's Minimum Data Set (MDS) dated 7/27/22, indicated R1 had severely impaired cognition. R1 did not have any behaviors and did not reject cares. R1 received insulin injections. The physician Order review as of 9/19/22, included the following orders: - Humalog 3 units (u) subcutaneous (sq) two times day after lunch (12:30 p.m.-2:30 p.m.) and after dinner 5:30 p.m.-7:30 p.m. With a start date of 6/7/22, for diabetes due to underlying condition with ketoacidosis without coma. Special instructions included do not give if resident does not have a snack. - Humalog insulin per sliding scale sq every day at bedtime between 7:00 p.m. and 10:00 p.m. with a start date of 6/7/22, for diabetes due to underlying condition with ketoacidosis without coma. Special instructions for blood glucose of 200-249 give 2 u, 250-299 give 4u, 300-350 give 6u, greater than 350 give 8u. - Humalog insulin 10u sq one time a day at 10:30 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Humalog insulin 7u sq one time a day at 4:30 p.m. with a start date of 6/7/22, for type 1	21545	from PM Nurse as ordered by the provider. NOC nurse administered the 10 units SQ Humalog after review of resident blood sugars with the provider. All residents have potential to be impacted by this deficient practice. All resident insulin orders and EMR insulin administration accuracy reviewed. Insulin order times adjusted in EMR with R1 to clarify insulin instructions to nursing staff. All other insulin orders found to be clear and concise. EMR (Yardi) system reviewed and found to have a large amount of information listed for the nurse that does not need to be address during their specific shift. This may limit their ability to process that information and identify potential medication errors before they occur. FHC working with Yardi technician's to eliminate unneeded information or clutter shown on the EMR. With R1's complex insulin orders/routine/snack intake a review of the 24 hour nurse to nurse form was reviewed and adjusted to reflect R1's specific insulin needs and timing. All licensed nursing staff educated and sent a Ymail (internal communication system) reflecting the proper administration/charting of insulin and administering insulin as ordered by the provider. Message also reflected the change in the 24 hour form to better track R1 insulin administration. Audits will be performed by DON/designee 3X/week for 4 weeks, 2X/ week for 2 weeks then monthly. Monitoring will be reported to the next QA&A and as needed. Committee will	

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21545	Continued From page 4 diabetes with ketoacidosis without coma. - Humalog insulin 12u sq one time a day at 7:30 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Humalog insulin per sliding scale sq before meals between 6:30 a.m.-9:00 a.m., 10:00 a.m.-12:00 p.m., 3:00 p.m.-5:00 p.m. With a start date of 6/7/22, for diabetes with hyperglycemia. Special instructions for blood glucose of 150-199 give 3u, 200-249 give 6u, 250-299 give 9u, 300-350 give 12u, greater than 350 give 15u. - Tresiba (a long acting insulin) 25u sq every day between 7:00 a.m.-11:00 a.m. with a start date of 6/7/22, for type 1 diabetes with ketoacidosis without coma. - Notify the doctor if blood sugars are less than 70 for two times or greater than 450 for two times. - During each of the three shifts every day give small dose Novolog with smaller meals and higher dose with bigger meals or extra cookies. With a start date of 6/7/22. Between 6:30 a.m. 2:30 p.m. on the day shift. Between 2:30 p.m. - 10:30 p.m. on the evening shift and between 10:30 p.m. - 6:30 a.m. on the night shift. - Accucheck (blood glucose check) every day at 2:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. With a start date of 6/7/22. A medication error report dated 9/2/22, indicated registered nurse (RN)-B notified registered nurse (RN)-A that R1's blood glucose was at 547 at 8:00 p.m. and then R1's blood glucose rose to 589 by bedtime. RN-A asked RN-B if R1's insulin was given. RN-B stated it was given but did not	21545	monitor and make ongoing recommendations as needed.	

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21545	Continued From page 5 clarify if R1's bedtime insulin had been administered. RN-B contacted the on-call provider. RN-A spoke with the on call triage nurse returning the call. The triage nurse gave orders to send R1 to the emergency room (ER) but wanted to confirm with the provider first. RN-A reviewed R1's medical record and noticed R1's insulin was not administered after dinner or at bedtime. R1 had only received insulin prior to dinner. RN-A checked R1's blood glucose and it had increased to 600. RN-A administered R1's insulin late at 11:00 p.m. and notified the triage nurse of the error. R1 refused to be sent to the ER. RN-A explained to R1 the complications and risks associated with declining to go into ER. R1 was negative for Kussmaul respirations (fast, deep breaths that occur in response to metabolic acidosis. Kussmaul respirations happen when the body tries to remove carbon dioxide, an acid, from the body by quickly breathing it out. Diabetic ketoacidosis is the most common cause of Kussmaul respirations). R1's vital signs were stable and was alert and orientated at baseline. R1's provider called to ask why R1 was not at the ER. RN-A reported R1 had refused and informed the physician R1's blood glucose was now at 381. (Normal blood glucose two hours after a meal for a person without diabetes is less than 140. Official American Diabetes Association's recommended blood glucose two hours after a meal for someone with diabetes is less than 180.) Progress note dated 9/3/22, at 7:45 a.m. written by RN-A indicated R1's daughter was notified of the elevated blood glucose and late administered insulin. R1's daughter expressed she was upset and frustrated because it was the second time that week R1 had missed her insulin. Progress notes dated 9/3/22, at 7:54 a.m. written	21545		

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21545	Continued From page 6 by RN-A indicated the on call physician was contacted to follow up and request recommended orders. The physician ordered a one time dose of 28u of Tresiba instead of the normal dose of 25u. During an interview on 9/19/22, at 12:22 p.m. with R1's family member (FM). FM stated she was informed of R1's elevated blood sugars and the missed insulins early the next morning. FM stated this had also happened earlier in the week, due to the facility using travel nurses. FM stated R1 was able to make her own decision to go or not to go to the hospital. FM would respect R1's choice and knows R1 would not want to go to the hospital. R1 was not compliant with her diet. FM further stated she liked the facility. She had good communication, they don't make excuses and don't sweep things under the rug. During an interview on 9/19/22, at 12:59 p.m. RN-C stated on 8/31/22, R1 did not receive dinner time insulin. The nurse practitioner was notified and did not give new orders, R1's blood glucose was not elevated more than usual. RN-C stated the only way to know if a medication was not given was when the following nurse reviewed the electronic medication administration record (EMAR). The nurses catch missed medications and complete an incident report. R1 did not have a negative outcome. R1 was noncompliant with her diet and had a signed informed consent on file. RN-C further stated R1 had dementia and if she ate something that would raise her blood sugar she would not remember or make the right food choices. During an interview on 9/19/22, at 2:49 p.m. RN-A stated RN-B came to her for physician's telephone number. RN-B reported to RN-A R1's blood glucose was 540 and 580. RN-A asked	21545		

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21545	Continued From page 7 RN-B if she gave R1 her insulin. RN-B said yes. RN-A then took the return call from triage. Triage recommended sending R1 to the ER. R1 refused to go to the ER. R1's blood glucose was then 600. RN-A checked the EMAR. R1's EMAR indicated R1 had received her before dinner insulin but had not received her dinner or bedtime insulin. At 11:00 p.m. RN-A gave R1 the bedtime sliding scale insulin. R1's blood glucose went down to 381 in about one and a half hours. RN-A further stated, she knows R1 well and what to do when R1's blood glucose is low or high and being R1 refused to go into ER RN-A gave R1 her bedtime sliding scale insulin. RN-A stated two missed dosed of insulin could have killed R1. RN-A assessed R1 through the night. In the morning R1's blood glucose was 250. RN-A stated the current EMAR system does not show medications that are flagged or missed. The previous system would tell you when and what was due. During an interview on 9/19/22, at 4:54 p.m. with the administrator. The administrator stated staff were trained on watching for medication errors. The EMAR showed medications that were not signed off. The system showed if a medication was missed. The director of nursing (DON) reviewed the insulins. The system also stated why the medication was missed and the reason the medication was not given was reviewed. The facility had a weekly meeting with the medical record software company and the administrator would bring the issue to the next meeting. On 9/20/22, at 1:43 p.m. RN-B was interviewed. RN-B stated she was an agency nurse, had worked at the facility for approximately two months. RN-B had worked at the facility on the afternoon shift for approximately 10 times. RN-B	21545		

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21545	Continued From page 8 worked on the unit of which R1 resides every time except one. RN-B stated she was familiar with R1 and was aware R1 had high blood sugars but they usually went down. This was the first time RN-B had to call a physician regarding R1's blood sugars. RN-B stated on 9/2/22, she thought she had given and charted all of R1's insulins. RN-B was not aware R1 did not receive her insulin as ordered. RN-B had not received a call back from the physician. RN-B reported this to RN-A of which RN-A told her she could leave as her shift was done. RN-A stated the EMAR system had a flag that indicated you missed a medication. RN-B did not look back to see if any medications were flagged and d id not realize R1's insulins were not charted. RN-B further stated she thought she had given the insulins. RN-B returned to work at the facility the next day on 9/3/22, and no one said anything about R1 not receiving the insulins. The facility's Medication Administration/Error policy dated 4/6/15, indicated it was the intention of the facility to keep residents free from significant medication errors. Significant medication error means one which causes the resident discomfort or jeopardizes the residents' health safety. All medications need to be administered are prescribed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medication orders are administered as ordered by the physician. 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	21545		

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21545	Continued From page 9 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		