

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Franciscan Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3910 Minnesota Avenue Duluth, MN 55802	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</p> <p>Based on interview and document review, the facility failed to protect a resident's right to be free from sexual abuse by staff for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Face Sheet undated, identified R1 had schizoaffective disorder, autistic disorder, bipolar disorder, intellectual disabilities, Alzheimer's disease, dementia, and schizophrenia.</p> <p>An Annual Notice of Right to Petition for Termination or Modification of Guardianship or Other Relief dated 6/3/24 indicated R1 had a court appointed guardian due to his inability to be his own decision maker.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment, delusions, and needed extensive assistance with all cares, and supervision for eating.</p> <p>R1's care plan dated 2/23/24, indicated R1 makes inappropriate sexual comments and may touch others inappropriately. Interventions included cares in pairs, redirect R1, remove R1 from the situation, and observe R1 during meals and activities.</p> <p>On 8/6/24 at 11:57 a.m., a progress note by registered nurse (RN)-A indicated R1 stated to RN-A that he had a girlfriend from housekeeping. R1 stated they loved each other, and she came in his room, and they touched each other.</p> <p>On 8/8/24 at 1:50 p.m., R1 stated two to three days ago he met housekeeper (H)-A, and she came into his room. He touched her breast and vagina with his hands, and they kissed. He knew he was not supposed to do anything with workers at the facility, but he loved H-A. He wanted this to happen as H-A was going to be his wife.</p> <p>On 8/8/24 at 3:03 p.m., RN-A stated on 8/6/24, R1 came to her and told her that he had a girlfriend, they loved each other. H-A had come into his room, and they touched each other. She didn't tell anyone about the incident, but documented it in R1's medical record as she knew it needed to be investigated. She was concerned if the interaction was consensual.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/9/24 at 8:38 a.m., H-A stated on 8/5/24 in the afternoon, she was in the dining room folding napkins and R1 asked her if she would be his girlfriend, and if she would go to his room. She told R1 she would be his girlfriend, and she went to R1's room. R1 touched her breasts and vagina with his hands. R1 asked her for a kiss, so she kissed him on the cheek. R1 asked for a kiss on the lips, so she kissed him on the lips. He told her he loved her, and they left the room and went to the dining room. R1 drank coffee and she left the facility as her shift was over. She was not aware she was not supposed to have relations with residents until her after the encounter with R1.</p> <p>On 8/9/24 at 9:37 a.m., occupational therapy assistant (OTA)-A stated after testing, she did not think R1 was cognitively intact enough to make his own choice of being in a relationship. OTA-A stated R1 was spontaneous and inappropriate at times, but did not understand the ramifications or consequences of his actions.</p> <p>The facility policy Protecting Victims of Maltreatment revised 10/18/21, directed the care center would protect a vulnerable adult from maltreatment.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</p> <p>Based on interview and document review, the facility failed to ensure allegations of sexual abuse were reported immediately (within two hours) to the State Agency (SA) for 1 of 3 residents (R1) reviewed for abuse.</p> <p>Findings include:</p> <p>R1's Face Sheet undated, identified R1 had schizoaffective disorder, autistic disorder, bipolar disorder, intellectual disabilities, Alzheimer's disease, dementia, and schizophrenia.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment, delusions, and needed extensive assistance with all cares, and supervision for eating.</p> <p>On 8/6/24 at 11:57 a.m., a progress note by registered nurse (RN)-A indicated R1 stated to RN-A that he had a girlfriend from housekeeping. R1 stated they loved each other, and she came in his room, and they touched each other.</p> <p>On 8/8/24 at 1:50 p.m., R1 stated two to three days ago he met housekeeper (H)-A, and she came into his room. He touched her breast and vagina with his hands, and they kissed. He knew he was not supposed to do anything with workers at the facility, but he loved H-A. He wanted this to happen as H-A was going to be his wife.</p> <p>On 8/8/24 at 3:03 p.m., RN-A stated on 8/6/24, R1 came to her and told her that he had a girlfriend, they loved each other. H-A had come into his room, and they touched each other. She didn't tell anyone about the incident, but documented it in R1's medical record as she knew it needed to be investigated. RN-A did not say why she did not report the incident.</p> <p>On 8/9/24 at 8:38 a.m., H-A stated on 8/5/24 in the afternoon, she was in the dining room folding napkins and R1 asked her if she would be his girlfriend, and if she would go to his room. She told R1 she would be his girlfriend, and she went to R1's room. R1 touched her breasts and vagina with his hands. R1 asked her for a kiss, so she kissed him on the cheek. R1 asked for a kiss on the lips, so she kissed him on the lips. He told her he loved her, and they left the room and went to the dining room. R1 drank coffee, and she left the facility as her shift was over. She was not aware she was not supposed to have relations with residents until her after the encounter with R1.</p> <p>On 8/9/24 at 11:58 a.m., RN-B stated it was expected staff report suspected or alleged abuse within two hours. If a resident told a staff member that they were in love with a staff and they touched each other, staff should report it right away.</p> <p>On 8/9/24 at 12:11 p.m., the director of nursing (DON) stated the expectation of staff is to report any alleged or potential abuse within two hours. She would consider the progress note written by RN-A on 8/6/24 potential abuse.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/9/24 at 12:33 p.m., the administrator stated staff should follow the policy and report abuse timely.</p> <p>The facility policy Maltreatment Reporting Guidelines revised 10/18/21, directed employees to report suspected maltreatment to a supervisor. If it is believed that the supervisor is responsible for the maltreatment the employee should then report to administrator. Any suspected maltreatment must be reported no later than 2 hours after the allegation is made.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>47790</p> <p>Based on interview, and document review, the facility failed to ensure required abuse, neglect, and exploitation training was completed for 1 of 3 staff (housekeeper [H]-A) whose personnel records were reviewed.</p> <p>Findings include:</p> <p>On 8/9/24 at 8:38 a.m., H-A stated she did not recall the last time she had abuse, neglect, and exploitation training.</p> <p>Review of personnel files on 8/9/24, indicated H-A had not had training on abuse, neglect, and exploitation since 6/7/21.</p> <p>On 8/9/24 at 12:11 p.m., the director of nursing (DON) stated every staff should have abuse training upon hire, annually, and as events occur.</p> <p>On 8/9/24 at 12:33 p.m., the administrator stated H-A has had no education on abuse, neglect, and exploitation since 2021. Staff should have this education upon hire and annually.</p> <p>A facility policy titled Maltreatment Prohibition policy reviewed 10/18/21 directed employees would be trained on Maltreatment Prohibition polices and procedures during the orientation process, and on an annual basis.</p>