

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 12/12/2024
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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>42587</p> <p>Based on interview, and document review, the facility failed to ensure current contact information of all pertinent State Agency and advocacy groups were posted at a level accessible to all residents. This had the potential to affect all residents who chose to view this information.</p> <p>Findings include:</p> <p>On 12/9/24 at 6:51 p.m., the resident council president gave permission to review the resident council meetings.</p> <p>The resident council meetings revealed rights were not reviewed at the 12/4/24, and 11/4/24, resident council meeting but were reviewed at the 10/7/24, and the 9/3/24, meeting.</p> <p>On 12/10/24 at 1:26 p.m., a resident council meeting was held with four residents in attendance (R2, R17, R12, and R26) all of whom required the use of a wheelchair. The four residents in attendance did not know where the state inspections were posted and volunteered some of the postings were too high to read for residents in a wheelchair and with poor eyesight.</p> <p>On 12/10/24 at 2:05 p.m., the large bulletin board in the main dining room was reviewed. The poster for information regarding the ombudsman was viewed at the top right hand corner of the bulletin board approximately six inches from the ceiling. There were not any pamphlets or cards for the ombudsman in the area near the bulletin board.</p> <p>On 12/12/24 at 1:56 p.m., the director of nursing (DON) reviewed the bulletin board and verified the information related to the ombudsman was approximately six inches from the ceiling and too high for residents in wheelchairs to read.</p> <p>The Combined Federal and State [NAME] of Rights dated 2/1/17, provided to all residents identified the facility must post, in a form and manner accessible and understandable to residents, and resident representatives this included information related to the Office of the State Long-Term Care Ombudsman program.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on interview and document review the facility failed to ensure a copy of the baseline care plan was provided to the resident and/or representative for 1 of 3 residents (R40) reviewed who was a new admission.</p> <p>Findings include:</p> <p>R40's Resident Face Sheet dated 12/12/24, identified R40 was admitted on [DATE], with spastic hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side and nontraumatic intercerebral hemorrhage.</p> <p>R40's 48 hour baseline care plan dated 11/19/24, identified R40's short term goals, health maintenance needs, pain intervention, safety concerns, medication concerns, and designated representative. R40's 48 hour baseline care plan identified needs and interventions for the following: eating, toileting, bathing, grooming, dressing, bed mobility, and transfers. However, the 48 hour baseline care plan lacked any indication that R40 or R40's representative had been offered or received a copy of the 48 hour baseline care plan.</p> <p>During an interview on 12/9/24 at 2:55 p.m., neither R40 nor his family member (FM)-A thought there had been any meetings regarding care plans.</p> <p>During an interview on 12/12/24 at 1:20 p.m., the director of nursing (DON) stated she would expect the 48 hour baseline care plan to be reviewed and a copy offered to the resident and or the resident representative. The DON stated the baseline care plan is important so staff know how to safely care for the resident.</p> <p>During an interview on 12/12/24 at 2:32 p.m., registered nurse (RN)-D provided a copy of the baseline care plan. RN-D stated the care plan was developed with the resident but that they did not offer a copy to the resident or the resident's representative. RN-B also verified the care plan was not ever offered to the resident or to the resident's representative.</p> <p>During an interview on 12/12/24 at 3:18 p.m., the corporate RN verified it was important to offer a copy of the baseline care plan so the resident and their family would be aware of the plan of care.</p> <p>Person Centered Care Planning dated 4/20/23, identified the facility would develop and implement a baseline care plan for each resident within 48 hours of admission. In addition, a summary or a copy of the baseline 48 hour care plan would be given to the resident and/or representative.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109</p> <p>Based on observation, interview, and document review, the facility failed to ensure timely repositioning for a resident with pressure ulcers (PU) for 1 of 2 residents (R25) reviewed for PU care.</p> <p>Findings include:</p> <p>R25's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of Parkinson's with dyskinesia, diabetes mellitus, stage two PU of sacral region, stage two PU of left buttock, dermatitis due to friction or contact with body fluids, non-pressure chronic ulcer of skin limited to breakdown of skin. R25 was dependent on staff for bed mobility.</p> <p>R25's care plan dated 1/5/23, identified dependence on staff to reposition in bed every two to three hours. R25 was incontinent of bowels and needed assistance after each episode with staff to check every two hours.</p> <p>During a continuous observation starting 12/12/24 at 8:14 a.m., R25 was observed in bed with the head of bed at about 20 degrees, with the bend in the bed partway up his back. R25 didn't appear to be propped to one side or the other and stayed in that position until nursing assistant (NA)-D came in at 10:02 a.m. During an interview at 10:05 a.m., NA-D stated the last time they were able to reposition R25 was shortly after 7 a. m. when the nurse had to give R25 some medications. NA-D also stated R25 should be repositioned every two hours, but the morning had been very busy, and they weren't able to get back to him until now. When NA-D rolled R25 onto his right side they noted the wound was not covered with a dressing and was actively bleeding bright red blood. NA-D called for help and registered nurse (RN)-D came in with supplies to clean and dress the wound. RN-D took measurements and commented it looked worse than it did the day before and she would be updating the provider again.</p> <p>During an interview on 12/12/24 at 3:30 p.m., RN-D stated she had been doing weekly measurements and wound assessment since the rounding wound provider stopped coming the end of November. Review of these measurements indicated the wound was worsening, however R25's provider was aware and rounding in the facility at least once a week. R25 has had a SCSA after hospitalization for sepsis, and then contracting COVID-19. RN-D shared R25 had an appointment with a wound provider on 12/16/24, and a new rounding wound provider would be starting at the facility next week. RN-D stated she would expect residents were turned and repositioned as care planned, and it would especially be important for a resident with a wound so they can help the wound as much as possible.</p> <p>A policy, Franciscan Health Center Repositioning Policy dated 10/23/16, identified its purpose was to establish a system to ensure every resident is repositioned as determined by individual assessment. All residents will be repositioned based on their individualized assessments, their preference or their request.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878</p> <p>Based on interview and document review, the facility failed to implement communication system with an outside dialysis facility to promote continuity of care and reduce the risk of complication for 1 of 1 resident (R21) reviewed for dialysis care.</p> <p>Findings include:</p> <p>R21's comprehensive Minimum Data Set (MDS) dated [DATE], identified R21 had intact cognition along with diagnoses of end stage renal disease and type 2 diabetes mellitus. R21's MDS also indicated resident received dialysis care while residing at the nursing facility.</p> <p>R21's care plan identified resident admitted to nursing facility on 11/6/24. Care plan identified resident received dialysis on Monday, Wednesday, and Friday. It identified staff actions of assessing dialysis site for bleeding or drainage and to update provider or dialysis unit with any concerns, recording weights from dialysis unit, and to observe resident for signs and symptoms of infection (redness, warmth, swelling) to access site, and to notify provider or dialysis unit with concerns.</p> <p>During interview on 12/10/24 at 1:02 p.m., health unit coordinator (HUC)-A stated dialysis communication sheet went with resident to dialysis center and was returned to facility with resident or faxed to the nursing facility. HUC-A stated R21 did not have a dialysis agreement in electronic medical record.</p> <p>During interview on 12/12/24 at 3:36 p.m., director of nursing (DON) stated dialysis agreement was important for resident care. DON further stated the agreement allowed for better communication between dialysis center and nursing facility, better continuation of care, and</p> <p>to be on the same page.</p> <p>R21's dialysis agreement dated 12/12/24, identified dialysis center as Fresenius Kidney Care, and the nursing facility contact person as registered nurse (RN)-A. Agreement did not identify dialysis contact person or the name and address of hospital for emergency room (ER) dialysis.</p> <p>Facility policy titled Dialysis Management revised 2/19/18, identified the need for a dialysis agreement between the nursing facility and the dialysis center. Policy further identified the agreement will include aspects of how the resident's care is to be managed, including: medical emergencies (name of hospital with emergency dialysis services), nonmedical emergencies (contact person at the dialysis center), process for interchange of information useful/necessary for the care of the resident, services each entity will be providing).</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on observation, interview and document review, the facility failed to ensure there were sufficient numbers of staff to ensure all resident cares were completed timely for 4 of 7 residents (R8, R23, R15, R22) who received their morning medications late, in addition for a resident with pressure ulcers needing assistance turning and repositioning for 1 of 3 residents (R25). This deficient practice had the potential to affect all 39 residents who resided in the facility.</p> <p>Findings include:</p> <p>Free of Medication errors of 5 percent or more</p> <p>see also F759</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 was moderately cognitively intact and had diagnoses which included, gastro-intestinal appliance, anxiety, depression, surgical aftercare following a surgery on the digestive system, dysphagia (difficulty swallowing foods or liquids arising from the throat or esophagus, ranging from mild to difficult to complete and painful blockage), nutritional deficiency, and history of malignant neoplasm of other organ system.</p> <p>R8's Physician Order Review as of 12/12/24, identified identified R8 had orders which included the following:</p> <p>fluoxetine 10 milligrams (mg) one tablet into gastric tube one time per day every day at morning 7:00 a.m.-10:00 a.m</p> <p>acetaminophen extra strength oral liquid 500 mg/5 milliliters (ml) 1000 mg every six hours every day and 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m</p> <p>midodrine 5 mg one tablet into gastric tube two times per day every day at 7:00 a.m., 5:00 p.m</p> <p>Pepcid 20 mg one tablet into feeding tube two times per day every day at morning 7:00 a.m.-10:00 a.m., 7:00 p.m.-10:00 p.m</p> <p>ProStat 1 ounce two time per day every day at 7:00 a.m.-11:00 a.m., 4:30 p.m.-8:30 p.m.</p> <p>Jevity 1.5 240 ml bolus three times per day every day at 10:00 a.m., 2:00 p.m., 6:00 p.m</p> <p>On 12/11/24 at 12:21 p.m., registered nurse (RN)-E prepared medications for R8, crushing each medication and placing the medication in labeled plastic medication cups. RN-E donned an isolation gown and gloves prior to entering R8's room, RN-E placed paper towels down on R8's table prior to placing medications, graduate, and 60 ml syringe. RN-E checked the patency of R8's gastric tube by pulling back and getting tube feeding returns, RN-E flushed R8's gastric tube with 30 ml of water. RN-E proceed to give each medication after adding water to dissolve the medication:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>fluoxetine 10 mg, 30 ml water flush</p> <p>acetaminophen 1000 mg, 30 ml water flush</p> <p>midodrine 5 mg, 30 ml water flush</p> <p>Pepcid 20 mg, 30 ml water flush</p> <p>ProStat 1 ounce, 30 ml water flush</p> <p>Jevity 1.5 240 ml bolus, followed by 300 ml of water</p> <p>R8's Time Variance Report for 12/11/24, identified the following:</p> <p>fluoxetine 10 mg due at 7:00 a.m.-10:00 a.m., given at 1:15 p.m.</p> <p>acetaminophen 1000 mg due at 12:00 p.m., given at 1:15 p.m.</p> <p>midodrine 5 mg due at 7:00 a.m., given at 1:15 p.m.</p> <p>Pepcid 20 mg due at 7:00 a.m.-10:00 a.m., given at 1:15 p.m.</p> <p>Jevity 1.5 240 ml due at 10:00 a.m., given at 1:15 p.m.</p> <p>R23's quarterly MDS dated [DATE], identified R23 was severely cognitively impaired and had diagnoses which included dementia, anemia, neurogenic bladder, and depression.</p> <p>R23's Physician Order Review as of 12/12/24, identified R23 had orders which included the following:</p> <p>divalproex sodium delayed release 125 mg two times per day every day at 7:00 a.m. -11:00 a.m. and 7:00 p.m. -10:00 p.m</p> <p>Miralax oral powder 17 grams (GM) per scoop by mouth one time per day in the a.m. every day at 7:00 a.m. - 11:00 a.m</p> <p>senna-s 8.6-50 mg two tablets by mouth two times per day every day at 7:00 a.m. - 10:00 a.m. and 7:00 p.m. - 10:00 p.m</p> <p>sertraline 25 mg one tablet one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>Tylenol 325 mg two tablets by mouth three times per day every day at 8:00 a.m., 2:00 p.m., 8:00 p.m</p> <p>R23's Time Variance Report for 12/11/24, identified the following:</p> <p>divalproex 125 mg due at 7:00 a.m. -11:00 a.m., given at 11:14 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Miralax 17 GM due at 7:00 a.m. - 11:00 a.m., given at 11:14 a.m.</p> <p>senna-s 8.6-50 mg due at 7:00 a.m. - 10:00 a.m., given at 11:14 a.m.</p> <p>sertraline 25 mg due at 7:00 a.m. - 10:00 a.m., given at 11:14 a.m.</p> <p>Tylenol 650 mg due at 8:00 a.m., given at 11:14 a.m.</p> <p>R15's, quarterly MDS dated [DATE], identified R15 was severely cognitively impaired and had diagnoses which included Alzheimer's disease and dysphasia (a communication disorder that affects a person's ability to understand and produce language).</p> <p>R15's Physician Order Review as of 12/12/24, identified R15 had orders which included the following:</p> <p>acetaminophen 500 mg two tablets by mouth two times per day every day at 10:00 a.m., 6:00 p.m</p> <p>senna 8.6 mg two tablets by mouth two times per day every day at 7:00 a.m. - 10:00 a.m and 7:00 p.m. - 10:00 p.m</p> <p>R15's Time Variance Report for 12/11/24, identified the following:</p> <p>acetaminophen 1000 mg due at 10:00 a.m., given at 10:59 a.m.</p> <p>senna 8.6 mg due at 7:00 a.m. - 10:00 a.m., given at 10:59 a.m.</p> <p>R22's significant change MDS dated [DATE], identified R22 was cognitively intact and had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), anemia, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), anxiety, and depression.</p> <p>R22's Physician Order Review as of 12/12/24, identified R22 had orders which included the following:</p> <p>cholecalciferol 25 micrograms (mcg) per 0.04 ml 25 mcg by mouth one time per day every at 7:00 a.m. - 10:00 a.m</p> <p>flomax 0.4 mg one capsule by mouth one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>furosemide 20 mg 0.5 tablet by mouth one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>levothyroxine 125 mcg one tablet by mouth one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>pantoprazole 20 mg one tablet by mouth one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>sertraline 100 mg one tablet by mouth one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Trelegy Ellipta inhalation aerosol powder breath activated 200-62.5 mcg/ACT one puff into the lungs one time per day every day at 7:00 a.m. - 10:00 a.m</p> <p>Tylenol 500 mg two tablets by mouth three times per day every day at 8:00 a.m., 2:00 p.m., 8:00 p.m</p> <p>R22's Time Variance Report for 12/11/24, identified the following:</p> <p>cholecalciferol 25 mcg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>flomax 0.4 mg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>furosemide 20 mg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>levothyroxine 125 mcg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>pantoprazole 20 mg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>sertraline 100 mg due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>Trelegy Ellipta inhaler due at 7:00 a.m. - 10:00 a.m., given at 12:14 p.m.</p> <p>Tylenol 1000 mg due at 8:00 a.m., given at 12:14 p.m.</p> <p>During an interview on 12/11/24 at 3:45 p.m., RN-E verified she was passing medications for 23-24 residents, crushing medications for seven residents (stated those medication passes could sometimes take 15 minutes or more), and about eight residents in enhanced barrier precaution rooms (requiring donning and doffing of personal protective equipment). RN-E verified medications for R8 were late despite not taking a morning break or lunch break and stated several other residents received their morning medications late as well (R23, R15, and R22).</p> <p>During an interview on 12/12/24 at 1:48 p.m., the director of nursing (DON) stated the nurses on the medication carts were passing medications for half of the residents in the building (census of 39 would be about 20 each) and they try to adjust the medication pass to keep it even. The DON verified it was important for residents to receive their medications timely to keep medication delivery on schedule.</p> <p>During an interview on 12/12/24 at 4:15 p.m., nursing assistant (NA)-C stated the nurse on the cart is really busy, if they would go to the nurse managers to get assistance on a new wound or pain they would be told the needed to go to the nurse on the cart first. NA-C stated the cart nurses were trying hard just to get the morning medications passed.</p> <p>Franciscan Health Center Order Pass Times undated, identified the following times for medication delivery:</p> <p>Daily- 7:00 a.m. - 10:00 a.m.</p> <p>Two times daily - 7:00 a.m. -11:00 a.m. and 7:00 p.m. - 10:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Three times daily - 7:00 a.m. - 10:00 a.m. and 12:30 p.m. - 2:30 p.m. and 7:00 p.m. - 10:00 p.m.</p> <p>Daily every six hours - midnight and 6:00 a.m. and noon and 6:00 p.m.</p> <p>48109</p> <p>Treatment or services to prevent or heal pressure ulcers (PU)s</p> <p>See also F686</p> <p>R25's significant change in status assessment (SCSA) MDS dated [DATE], identified intact cognition and diagnoses of Parkinson's with dyskinesia, diabetes mellitus, stage two PU of sacral region, stage two PU of left buttock, dermatitis due to friction or contact with body fluids, non-pressure chronic ulcer of skin limited to breakdown of skin. R25 was dependent on staff for bed mobility.</p> <p>R25's care plan dated 1/5/23, identified dependence on staff to reposition in bed every two to three hours. R25 was incontinent of bowels and needed assistance after each episode with staff to check every two hours.</p> <p>During a continuous observation starting 12/12/24 at 8:14 a.m., R25 was observed in bed with the head of bed at about 20 degrees, with the bend in the bed partway up his back. R25 didn't appear to be propped to one side or the other and stayed in that position until NA-D came in at 10:02 a.m. During an interview at 10:05 a.m., NA-D stated the last time they were able to reposition R25 was shortly after 7 a.m. when the nurse had to give R25 some medications. NA-D also stated R25 should be repositioned every two hours, but the morning had been very busy, and they weren't able to get back to him until now. When NA-D rolled R25 onto his right side they noted the wound was not covered with a dressing and was actively bleeding bright red blood. NA-D called for help and RN-D came in with supplies to clean and dress the wound. RN-D took measurements and commented it looked worse than it did the day before and she would be updating the provider again.</p> <p>During an interview on 12/12/24 at 3:30 p.m., RN-D stated she had been doing weekly measurements and wound assessment since the rounding wound provider stopped coming the end of November. Review of these measurements indicated the wound was worsening, however R25's provider was aware and rounding in the facility at least once a week. R25 has had a SCSA after hospitalization for sepsis, and then contracting COVID-19. RN-D shared R25 had an appointment with a wound provider on 12/16/24, and a new rounding wound provider would be starting at the facility next week. RN-D stated she would expect residents were turned and repositioned as care planned, and it would especially be important for a resident with a wound so they can help the wound as much as possible.</p> <p>A policy, Franciscan Health Center Repositioning Policy dated 10/23/16, identified its purpose was to establish a system to ensure every resident is repositioned as determined by individual assessment. All residents will be repositioned based on their individualized assessments, their preference or their request.</p> <p>Staffing Interviews</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/11/24 at 1:07 p.m., RN-C stated they were responsible for medications and treatments for 20 residents, which left 27 residents for the RN on the other side. RN-C provided it was difficult to get their work done on their shift and ran over to the next shift almost every time they worked. RN-C also stated it was nearly impossible to pass medications for 20 residents and be available to answer questions the NAs may have, or if they needed help, or if a resident wanted to talk. RN-C stated they don't always take their lunch when they are just working eight hours, but if they did a double, they would for sure take their half hour break.</p> <p>During an interview on 12/12/24 at 7:45 a.m., NA-D and NA-H stated they were short on Monday 12/9/24 and again today. NAs -D and -H shared they were often short on this shift, and it was frequent that the restorative NA would be pulled from their restorative duties to work the missing staff person's shift. NA-H added they used to have three NAs on the overnight shift and now there are only two, and for the afternoons they had 5 NAs and now have four. NAs -D and -H also stated they have talked with management and were told the staffing fits with their census. NA-H added the residents they care for were heavier care, needing two-person lifts and lots of redirection for behavior.</p> <p>During an interview on 12/12/24 at 3:29 p.m., the facility scheduler (FS)-A stated she posted open shifts in the upcoming schedule four weeks in advance so facility staff and then agency staff could pick up the open spots, however the schedule still went out with open shifts. FS-A confirmed staff would complain to her and vented about being short-staffed. The nurse managers would help by trying to even out the care groups. FS-A stated when they had a call in, they would try to replace the shift and if they weren't able then they would have to mandate but only the facility-employed NAs could be mandated, not the supplemental nursing agency NAs. FS-A explained there was one restorative aide (RA) scheduled, but they were always an aid first and would be pulled to fill a NA call-in, which was difficult for one of the two weekends because there wasn't a scheduled RA that weekend.</p> <p>During an interview on 12/12/24 at 3:56 p.m., NA-G stated concerns with the staffing levels for overnight as there were only two NAs on and it was hard to get their work done and they didn't take breaks. NA-G provided it was difficult to get through one whole round done on the residents before it was time to start the next round. NA-G had talked with management but was told this was the way it was.</p> <p>During an interview on 12/12/24 at 4:14 p.m., NA-F stated even on days things went smoothly, there still wasn't enough time to get their work done and they had trouble getting their breaks in. NA-F stated the biggest problem was when a resident needed to be checked on for things only a nurse could do, like a new wound or pain, they were told to tell the cart nurse first. But the cart nurses were trying so hard to just get the medications out, it took them most of their shifts just doing that.</p> <p>Facility Assessment and Payroll-Based Journal Report</p> <p>Review of the facility assessment dated [DATE], identified a plan for licensed staff providing direct care on the weekdays and weekends to be two per day and evening shift and one per overnight shift; and NAs at five per day shift, four per afternoon shift and two per overnight shift.</p> <p>The Centers for Medicare and Medicaid Services (CMS) quarterly reporting of the facility's payroll-based journal for the fourth quarter (July 1 to September 30) of the fiscal year 2024 identified excessively low weekend staffing levels.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of facility-submitted daily staffing worksheets from 11/10/24 to 12/12/24 identified the following days to have lower than planned staffing:</p> <p>11/10 afternoon shift short 1.5 NA hours</p> <p>11/11 day shift short 8 NA hours, no RA scheduled</p> <p>11/12 day shift short 8 NA hours, RA pulled to cover 8 additional NA hours</p> <p>11/16 day shift short 1.5 NA hours, afternoon shift short 1.5 RN hours</p> <p>11/18 day shift RA pulled to cover 8 NA hours</p> <p>11/20 no RA scheduled</p> <p>11/23 afternoon shift short 2 NA hours</p> <p>11/24 day shift short 8 NA hours, no RA; afternoon shift short 2 NA hours</p> <p>11/25 day shift short 12.5 NA hours, no RA scheduled; afternoon shift short 2.5 NA hours</p> <p>11/26 day shift no restorative scheduled; afternoon shift short 2 NA hours</p> <p>11/27 day shift no RA scheduled</p> <p>11/28 day shift RA pulled to cover 8 NA hours; afternoon shift short 2 NA hours</p> <p>11/29 day shift short 8 NA hours, no RA scheduled</p> <p>11/30 day shift short 8 NA hours, no RA scheduled</p> <p>12/1 day shift short 8 NA hours, no RA scheduled</p> <p>12/4 day shift RA pulled to cover 8 NA hours</p> <p>12/5 day shift RA pulled to cover 8 NA hours</p> <p>12/6 overnight shift short 1.5 NA hours</p> <p>12/7 afternoons short 1.5 NA hours</p> <p>12/8 day shift RA pulled to cover 8 NA hours; afternoon shift short 1.5 NA hours</p> <p>12/9 day shift short 12.5 NA hours, no RA scheduled: afternoons short 2 NA hours</p> <p>12/10 afternoon shift short 3 NA hours</p> <p>12/12 day shift RA pulled to cover 8 NA hours; afternoon shift short 2 hours</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878</p> <p>Based on observation, interview and document review, the facility failed to investigate, review, and analyze underlying causes of resident's delusions for 1 of 1 resident (R11) who was reviewed for behaviors.</p> <p>Findings include:</p> <p>R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had no cognitive impairment and diagnoses included congestive heart failure, type 2 diabetes mellitus, hypo-osmality and hyponatremia (condition of having abnormally low levels of electrolytes and other fluids in the blood),, paroxysmal atrial fibrillation (an irregular heartbeat that comes and goes), hypertension, cirrhosis of the liver, depression, hyperlipidemia, and spontaneous bacterial peritonitis (bacterial infection in abdominal fluids without an obvious source for the infection). R11's MDS had exhibited behaviors of hallucinations and delusions within the previous seven days.</p> <p>R11's care plan dated 10/28/24, identified R11 had short term memory problems and/or periods of confusion/disorientation/forgetfulness. Care plan also identified staff interventions to monitor R11 for any cognitive changes and update provider as needed, orient resident to day, month, and year during interactions as needed, and to provide resident with redirection as needed.</p> <p>During observation and interview on 12/10/24 at 8:46 a.m., R11 stated she doesn't like all the people in her room. R11 and surveyor were the only people in the room. R11 asked surveyor to leave room.</p> <p>Progress notes identified the following:</p> <p>-On 6/15/24 at 2:06 a.m., staff reported R11 stated 'I'm not moving, and I don't want any kids in here.</p> <p>-On 6/16/24 at 4:08 a.m., staff reported 'twice this this [sic], resident spilled her [NAME] of water. Each time resident stated that god damn cat keeps jumping up here knocking my things off the table! I'm sick of the damn cats, and just don't want them here anymore! Resident motioned as if cat was crawling on her and in her bed.'</p> <p>-On 6/19/24 at 9:25 p.m., staff reported R11 'spoke of babies being on top of her bed and under her linens.'</p> <p>-On 6/21/24 at 12:27 p.m., staff reported R11 'does continue with delusional thoughts and statements of there is a cat in the room and knocking things off shelves, her teddy bear is a real baby.'</p> <p>-On 6/30/24 at 3:54 a.m., staff reported R11 'slept very little this shift. Increasingly confused. Upset with so many children in my bed. Resident gesturing to children and 'shooing' them out of her bed.'</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 7/5/24 at 4:27 a.m., R11 requested 'baby formula water' from staff so she could feed the 'babies' in her room.</p> <p>-On 7/5/24 at 10:02 a.m., staff reported 'yesterday on day shift, Resident was very confused and kept talking about her boyfriend [NAME] coming to pick her up. Changed clothes multiple times in the morning shift.' R11 seen leaving out front door and was stopped by staff. Call placed to daughter, daughter states R11 has been calling a lot more often and they noted she is more forgetful and confused. 'Daughter states this is all new since her admission at the facility.'</p> <p>-On 7/10/24 at 2:15 p.m., nursing staff reported Daughter [NAME] at facility and said resident has dementia. Writer reviewed diagnosis list and did not see dementia or any cognitive impairment diagnosis. Update placed in rounding book.</p> <p>-On 7/17/24 at 1:43 p.m., staff reported resident has changed her clothes at least 5 times this day shift. She is sitting in the bathroom and stay in there for up to an hour. This is not new behavior and happens most days.</p> <p>-On 7/18/24 at 1:36 p.m., staff reported resident removed all of her clothes from her closet and stacked them on the bed. She wants to 'get out of here' and 'this is a terrible place.' She has changed her clothes at least 4 times today and said she is going to change her clothes before supper.</p> <p>-On 7/19/24 at 10:19 a.m., RN-B reported Daughter requesting Writer go see if Resident has clothes in her room because Resident was reporting to Daughter that she doesn't have anything to wear. Daughter reports that she does Residents laundry because Resident is very particular with her stuff and does not like certain articles of clothing dried. Writer entered room and Resident was sitting in doorway of her bathroom in her wheelchair unclothed with a brief under her, but the brief was not secured. Writer assisted Resident with changing into clothes which she did have a few outfits hanging in her closet. Resident was very pleasant and accepting of Writer's help. Writer noted Resident had clothes and bedding all over room. There was a pile of clothes in a basket that looked clean, and Writer asked if they were clean and I could put them away and Resident said, oh no, those are dirty. Resident did not want Writer to put away or organize any clothes in her room. Writer updated Daughter.</p> <p>-On 7/30/24 at 10:52 p.m., staff reported Resident refusing to let staff help with getting her ready for bed. Writer found resident in bathroom putting a tab brief on, resident also had a pull up brief and a disposable underwear on. Writer tried telling resident she should only wear one brief, but resident stated she does this all the time.</p> <p>-On 8/5/24 at 1:28 p.m., staff reported Resident took meds this am. She slept in. She did have Oreo cookies crushed up on her floor next to bed. The CNA attempted several times t/o the am to get her some food, offered to bring her to brunch. She tends to circle around in her room and change outfits. She had a pile of hangers on the floor. A few minutes ago I asked her if she had lunch and she said she hasn't eaten anything today. She was in an irritable mood most of the morning. She talks a lot about wanting her family to come and help her. This is not new behavior for her. A large group of family members visited yesterday.</p> <p>-On 8/21/24 at 1:25 p.m., reported Daughter [NAME] states that Resident called and left her a message stating that Residents mother was there which she said that it is probably just her dementia.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 9/8/24 at 11:13 a.m., staff reported Resident continues to double up her briefs when wearing them. Resident was educated on brief usage but refused to change what she states she has been doing for a long time.</p> <p>-On 9/16/24 at 2:13 p.m., staff reported Resident continues to double up her briefs despite education regarding this.</p> <p>-On 9/21/24 at 10:26 a.m., staff reported Resident refused most morning medication. She yelled at writer multiple times to Get those damn people out of here! when inquiring what people resident was talking about, resident stated All of those shits! They're not allowed in here! I'm not doing any of this! Get out!. Writer reapproached resident 30 minutes later and resident was agreeable to taking only tramadol, nasal spray, and insulin. Resident told writer again (referring to her medication,)I'm not doing all of that bullshit!</p> <p>-On 9/21/24 at 1:18 a.m., staff reported Resident also has been double briefing and refuses to wear just one brief. Resident has been going through her drawers and cabinets and removing the contents and setting them on all surfaces including the floor.</p> <p>-On 9/27/24 at 2:56 p.m., staff reported Resident appeared to be hallucinating in the bathroom during shift and said, there are 2-3 mice in here that no one will get rid of. They have red eyes and they show their teeth at me.</p> <p>-On 10/4/24 at 5:33 a.m., staff reported Resident was found taking all of her belongings off of her shelves and out of her drawers. When asked why, resident stated, the kids came in her and smeared poop all over everything. According to resident, she needed to wash everything with soap and water to get the poop off. Resident stated she didn't know the kids who got in my room. Resident began washing her items in her bathroom sink. All efforts to redirect resident from ambulating independently and washing her belongings were ineffective with resident stating I have to take care of this and disregarding prompts and encouragement from staff to help ensure her safety.</p> <p>-On 11/5/24 at 11:08 a.m., staff reported Resident found putting fresh hospital gown on, getting ready for bed and taking out dentures. Resident said she is confused often and thought that it was night. Writer opened up resident curtains and helped her change into day clothes, reoriented her to daytime and encouraged resident to attend brunch for change in scenery.</p> <p>-On 12/1/24 at 4:14 a.m., staff reported Resident reported many people in her room and was observed looking around the room as if she were watching something. Resident also reported that someone was in her room and urinated on the floor. Writer did not find any urine on resident's floor.</p> <p>-On 12/3/24 at 2:31 p.m., staff reported Resident appears to be needing additional assistance with cares. Resident found second shift in a row barefooted in bathroom with head towards the ground and towels spread over the floor wiping up large quantities of incontinent episodes. Discussed resident using call light for help moving forward and resident said she would be willing to receive help with toileting and stated she had been embarrassed.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 12/10/24 at 3:32 p.m., staff reported Nurse aid reported to writer during morning that resident was c/o people in her room that wouldn't leave. Writer went to assess resident, and resident was in bed and notably agitated. Resident said, If something doesn't change, I'm going to leave this place! This is ridiculous and those people won't leave! Resident motioned at a large 2-foot-tall snowman, Mrs. Clause doll and another stuffed figurine. Writer pointed to the items in resident room and said, You mean, these people? Resident confirmed. Items removed from room and put on top of resident armoire. Family notified of room decor change.</p> <p>During interview on 12/11/24 at 1:20 p.m., registered nurse (RN)-C stated all staff received education on dementia and mental health conditions. RN-C also stated staff received education on signs and symptoms of mental health conditions. RN-C further stated she was unsure about R11's diagnoses. RN-C identified interventions for R11's hallucinations as redirection, reassurance, and reorientation to situation.</p> <p>During interview on 12/11/24 at 1:44 p.m., nursing assistant (NA)-A stated staff receive training on behavioral health and dementia when hired. NA-A stated training included signs and symptoms of mental health problems.</p> <p>During interview on 12/11/24 at 2:04 p.m., NA-B stated staff receive training on dementia and mental health conditions. NA-B also stated training was done when hired and every year. NA-B identified interventions for R11 included redirection and having a different staff member approach resident if agitated.</p> <p>During interview on 12/12/24 at 2:01 p.m., NA-B stated staff receive training on dementia and mental health. NA-A further stated training included signs and symptoms of mental health problems. NA-A also identified interventions for R11 as redirection and reorienting resident to reality.</p> <p>During interview on 12/12/24 at 3:35 p.m., director of nursing (DON) stated it was important for staff to know about mental health when caring for residents. DON identified residents with mental health conditions could require a different care approach than other residents. DON further identified the importance of staff knowing about resident behaviors and how to manage those behaviors.</p> <p>Facility assessment dated [DATE], identified staff training for behavioral health at orientation and annually.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 13.79% with 4 errors out of 29 opportunities for error involving 1 of 7 residents (R8) who were observed during the medication passes.</p> <p>Findings include:</p> <p>R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 was moderately cognitively intact and had diagnoses which included, gastro-intestinal appliance, anxiety, depression, surgical aftercare following a surgery on the digestive system, dysphagia (difficulty swallowing foods or liquids arising from the throat or esophagus, ranging from mild to difficult to complete and painful blockage), nutritional deficiency, and history of malignant neoplasm of other organ system.</p> <p>R8's Physician Order Review as of 12/12/24, identified the following orders:</p> <p>fluoxetine 10 milligrams (mg) one tablet into gastric tube one time per day every day at morning 7:00 a.m. -10:00 a.m</p> <p>acetaminophen extra strength oral liquid 500 mg/5 milliliters (ml) 1000 mg every six hours every day and 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m</p> <p>midodrine 5 mg one tablet into gastric tube two times per day every day at 7:00 a.m., 5:00 p.m</p> <p>Pepcid 20 mg one tablet into feeding tube two times per day every day at morning 7:00 a.m.-10:00 a.m., 7:00 p.m.-10:00 p.m</p> <p>ProStat 1 ounce two time per day every day at 7:00 a.m.-11:00 a.m., 4:30 p.m.-8:30 p.m.</p> <p>Jevity 1.5 240 ml bolus three times per day every day at 10:00 a.m., 2:00 p.m., 6:00 p.m</p> <p>On 12/11/24 at 12:21 p.m., registered nurse (RN)-E prepared medications for R8, crushing each medication and placing the medication in labeled plastic medication cups. RN-E donned an isolation gown and gloves prior to entering R8's room, RN-E placed paper towels down on R8's table prior to placing medications, graduate, and 60 ml syringe. RN-E checked the patency of R8's gastric tube by pulling back and getting tube feeding returns, RN-E flushed R8's gastric tube with 30 ml of water. RN-E proceed to give each medication after adding water to dissolve the medication:</p> <p>fluoxetine 10 mg, 30 ml water flush</p> <p>acetaminophen 1000 mg, 30 ml water flush</p> <p>midodrine 5 mg, 30 ml water flush</p> <p>Pepcid 20 mg, 30 ml water flush</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>ProStat 1 ounce, 30 ml water flush</p> <p>Jevity 1.5 240 ml bolus, followed by 300 ml of water</p> <p>R8's Time Variance Report for 12/11/24, identified the following:</p> <p>fluoxetine 10 mg due at 7:00 a.m.-10:00 a.m., given at 1:15 p.m.</p> <p>acetaminophen 1000 mg due at 12:00 p.m., given at 1:15 p.m.</p> <p>midodrine 5 mg due at 7:00 a.m., given at 1:15 p.m.</p> <p>Pepcid 20 mg due at 7:00 a.m.-10:00 a.m., given at 1:15 p.m.</p> <p>Jevity 1.5 240 ml due at 10:00 a.m., given at 1:15 p.m.</p> <p>During an interview on 12/11/24 at 3:45 p.m., RN-E verified she was passing medications for 23-24 residents, crushing medications for seven residents (stated those medication passes could sometimes take 15 minutes or more), and about eight residents in enhanced barrier precaution rooms (requiring donning and doffing of personal protective equipment). RN-E verified medications for R8 were late despite not taking a morning or lunch break and stated several other residents received their morning medications late as well (R23, R4, and R22).</p> <p>During an interview on 12/12/24 at 1:48 p.m., the director of nursing (DON) stated the nurses on the medication carts were passing medications for half of the residents in the building (census of 39 would be about 20 each) and they try to adjust the medication pass to keep it even. The DON verified it was important for residents to receive their medications timely to keep medication delivery on schedule.</p> <p>Franciscan Health Center Order Pass Times undated, identified the following times for medication delivery:</p> <p>Daily- 7:00 a.m. - 10:00 a.m.</p> <p>Two times daily - 7:00 a.m. -11:00 a.m. and 7:00 p.m. - 10:00 p.m.</p> <p>Three times daily - 7:00 a.m. - 10:00 a.m. and 12:30 p.m. - 2:30 p.m. and 7:00 p.m. - 10:00 p.m.</p> <p>Daily every six hours - midnight and 6:00 a.m. and noon and 6:00 p.m.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>42587</p> <p>Based on observation, interview, and document review the facility failed to ensure medications and supplies available for use in a the medication storage room were not expired. This had the potential to affect all 39 residents residing in the facility.</p> <p>Findings include:</p> <p>On 12/11/24 at 1:35 p.m., during an inspection of the locked medication room with the director of nursing (DON) the following observations were made:</p> <ul style="list-style-type: none"> -lab cart for blood draws had nine yellow top blood tubes with an expiration date of 10/31/24 -all four respiratory viral panel swabs were expired -two bottles of hibiclens had expiration dates of 8/2024 and 11/2024 -two tubes of Bacitracin ointment with expiration dates of 11/2023 <p>During an interview on 12/11/24 at 2:09 p.m., the DON stated would not want to use expired medications as could not be sure of their potency and efficacy. The DON stated it was the responsibility of the night shift to check for out dated supplies but they did not have any check off sheet to ensure it was completed.</p> <p>Night Nurse Weekly Duties undated, identified each Tuesday the night nurse would check for dates on opened medications and expired medication on both medication carts, treatment carts, and the medication room. Highlight any dates that expire within the current month.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on observation, interview, and document review, the facility failed to ensure appropriate use of personal protective equipment (PPE) when exiting a resident's room (R32) with a Covid-19 positive diagnosis.</p> <p>Findings include:</p> <p>R32's significant change Minimum Data Set (MDS) dated [DATE], identified R32 was severely cognitively impaired and had a diagnosis of Covid-19.</p> <p>On 12/11/24 at 1:05 p.m., two staff were observed outside of R32's room, they both donned isolation gowns, removed their surgical masks and then put on N-95 masks, then put on gloves, knocked and entered R32's room. R32's door had a sign up indicating airborne precautions need to be followed. PPE supplies were hanging on the door, there were no trash receptacles outside of the room.</p> <p>On 12/11/24 at 1:15 p.m., Nursing assistants (NA)-B and NA-E were observed exiting R32's room wearing surgical masks. NA-B stated they doffed (removed) their N-95 masks in the room and put on clean surgical masks that were stored inside the room. NA-B stated they had questioned the nurse managers about the process but were told it was the proper way to doff.</p> <p>During an interview on 12/11/24 at 1:23 p.m., registered nurse (RN)-B stated staff were educated on donning and doffing through their computerized education program during orientation and annually. RN-B stated in an airborne isolation room (Covid-19) she would expect staff to remove their gloves, goggles, remove their isolation gown, and remove their N-95 mask in the room and put on a new surgical mask kept in the room. RN-B stated they would only have their masks off inside the room for a few seconds.</p> <p>During an interview on 12/12/24 at 1:47 p.m., the director of nursing (DON) stated staff should not remove their N-95 mask until they were outside of the Covid-19 room. The DON stated removing the mask inside the Covid-19 room would increase their risk for exposure to Covid-19.</p> <p>Suspected or Confirmed Corona Virus Outbreak dated 7/25/23, directed staff to do the following: If disposable respirator is used, it should be removed and discarded after exiting the resident room and closing the door. Perform hand hygiene after discarding.</p> <p>Airborne Respirator/Contact Precautions door signage dated 5/30/19, directed staff to wear a powered aire purifying respirator (PAPR) or fit tested N-95 mask and eye protection prior to entering the room.</p> <p>How to Safely remove PPE instructions from the Centers for Disease Control (CDC) no date. Remove all PPE before exiting the patient room except a respirator, if worn.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on interview and document review, the facility failed to ensure immunization records were up to date for 2 of 5 residents (R13, R40) who were new admissions. In addition, the facility failed to ensure residents and/or resident representatives were educated on and residents offered pneumococcal vaccines (vaccines given to prevent pneumonia) upon admission for 1 of 5 residents (R17). The facility further failed to provide education and offer the influenza vaccine to 3 of 5 residents (R11, R13, R40) reviewed for immunizations.</p> <p>Findings include:</p> <p>Immunization Records</p> <p>R13's Resident Face Sheet identified R13 was admitted on [DATE], was over the age of 50 and had diagnoses which included hypertensive heart disease, anxiety disorder, atrial fibrillation and flutter (a condition in which the heart beats too fast and irregularly and rapid heart rate that is organized and repetitive but still faster than normal), and adult failure to thrive.</p> <p>A review of R13's record did not reveal a Minnesota Immunization Information Connection (MIIC) report. The facility was not able to provide any immunization history for R13.</p> <p>R40's Resident Face Sheet identified R40 was admitted on [DATE], was over the age of 50 and had diagnoses which included spastic hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side and nontraumatic intercerebral hemorrhage (stroke).</p> <p>A review of R40's record did not reveal a MIIC report. The facility was not able to provide any immunization history for R40.</p> <p>During an interview on 12/12/24 at 10:18 a.m., registered nurse (RN)-B stated they had nothing on record for an immunization history for R40 and was unsure if anyone had followed up on his vaccination status with R40 or with R40's representative.</p> <p>During an interview on 12/12/24 at 10:26 a.m., RN-A stated she thought R13 was anti-vaccine and didn't like vaccinations. RN-A did not think vaccinations had been offered and did not have any information on education or declinations of vaccines from the resident or the resident's representative.</p> <p>During an interview on 12/12/24 at 1:38 p.m., the director of nursing (DON) stated she would expect staff to have identified a resident's vaccine status upon admission so they could be educated and offered the appropriate vaccines.</p> <p>Pneumococcal vaccine</p> <p>R17's Resident Face Sheet identified R17 was admitted on [DATE], was over the age of 50 and had diagnoses which included cerebrovascular disease, hypertension, weakness, personal history of transient ischemic attack, cerebral infarction (stroke), diabetes mellitus, and chronic pain.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R17's immunization history was as follows:</p> <p>Pneumo-PCV13 given 10/13/16</p> <p>Pneumo-PPSV23 given 2/8/11</p> <p>According to the PneumoRecs VaxAdvisor Centers for for Disease Control and Prevention (CDC) R17 was eligible for one dose of PCV20 or PCV21 at least five years after the last pneumococcal vaccine dose.</p> <p>During an interview on 12/12/24 at 10:24 a.m., RN-B was not aware of the PneumoRecs VaxAdvisor and stated she just went by the MIIC to determine if a resident was up to date with pneumococcal vaccines and did not have any conversations regarding vaccine eligibility with R17's provider.</p> <p>During an interview on 12/12/24 at 1:38 p.m., the director of nursing stated she would expect staff to review th CDC guidelines for pneumococcal vaccines and educate and offer as appropriate.</p> <p>Influenza vaccine</p> <p>R11's Resident Face Sheet identified R11 was admitted on [DATE], and had diagnoses which included chronic heart failure, hypertension, multidrug resistant organism (MDRO), diabetes mellitus, and depression.</p> <p>R11's immunization record identified R11's last influenza vaccine was on 10/20/23.</p> <p>R13's Resident Face Sheet identified R13 was admitted on [DATE], was over the age of 50 and had diagnoses which included hypertensive heart disease, anxiety disorder, atrial fibrillation and flutter (a condition in which the heart beats too fast and irregularly and rapid heart rate that is organized and repetitive but still faster than normal), and adult failure to thrive.</p> <p>A review of R13's record did not reveal a Minnesota Immunization Information Connection (MIIC) report. The facility was not able to provide any immunization history for R13.</p> <p>R40's Resident Face Sheet identified R40 was admitted on [DATE], was over the age of 50 and had diagnoses which included with spastic hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side and nontraumatic intercerebral hemorrhage (stroke).</p> <p>A review of R40's record did not reveal a MIIC report. The facility was not able to provide any immunization history for R40.</p> <p>During an interview on 12/12/24 at 10:27 a.m., RN-B was not sure if an influenza vaccine had been offered to R11, R13, or R40.</p> <p>The facility was unable to provide documentation that R11, R13, or R40 had received the influenza vaccine. In addition, the facility was not able to provide information that the above listed residents received education about the influenza vaccine. The facility was also not able to provide signed declinations by the residents or their representatives for the influenza vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24 at 1:38 p.m., the director of nursing (DON) stated the influenza vaccine clinic was done by Thrifty [NAME] Pharmacy and the licensed social worker (LSW)-A obtained the consents. The DON was not sure what occurred if a resident declined the vaccine.</p> <p>Resident Immunizations dated 9/29/23, identified the following:</p> <p>An immunization history will be taken upon admission.</p> <p>The resident's immunization history will be documented and maintained on the immunization record for each resident in the resident's medical record.</p> <p>Pneumococcal vaccines will be offered to each resident according to the current recommendations from the CDC.</p> <p>The influenza vaccine will be offered to residents annually between October 1st and March 31st.</p> <p>Those residents assessed to be cognitively unable to make decisions will have the written education provided on admission (and at the beginning of every flu season for the influenza vaccine) to the POA/family member/significant other identified in the record as the primary contact.</p> <p>The resident or the resident's representative has the opportunity to refuse the immunization.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on interview and document review, the facility failed to ensure residents were educated on and offered COVID-19 vaccinations upon admission to 3 of 5 residents (R11, R13, R40).</p> <p>Findings include:</p> <p>R11's Resident Face Sheet identified R11 was admitted on [DATE], and had diagnoses which included chronic heart failure, hypertension, multidrug resistant organism (MDRO), diabetes mellitus, and depression.</p> <p>R11's immunization record identified R11's last COVID-19 vaccine was on 10/19/23.</p> <p>R13's Resident Face Sheet identified R13 was admitted on [DATE], was over the age of 50 and had diagnoses which included hypertensive heart disease, anxiety disorder, atrial fibrillation and flutter (a condition in which the heart beats too fast and irregularly and rapid heart rate that is organized and repetitive but still faster than normal), and adult failure to thrive.</p> <p>A review of R13's record did not reveal a Minnesota Immunization Information Connection (MIIC) report. The facility was not able to provide any immunization history for R13.</p> <p>R40's Resident Face Sheet identified R40 was admitted on [DATE], was over the age of 50 and had diagnoses which included spastic hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting right dominant side and nontraumatic intercerebral hemorrhage (stroke).</p> <p>A review of R40's record did not reveal a MIIC report. The facility was not able to provide any immunization history for R40.</p> <p>During an interview on 12/12/24 at 10:18 a.m., registered nurse (RN)-B stated they had nothing on record for an immunization history for R40 and was unsure if anyone had followed up on his vaccination status with R40 or with R40's representative.</p> <p>During an interview on 12/12/24 at 10:26 a.m., RN-A stated she thought R13 was anti-vaccine and didn't like vaccinations. RN-A did not think vaccinations had been offered and did not have any information on education or declinations of vaccines from the resident or the resident's representative.</p> <p>During an interview on 12/12/24 at 10:27 a.m., RN-B stated she was unsure if R11 had been offered any vaccines.</p> <p>During an interview on 12/12/24 at 1:38 p.m., the director of nursing (DON) stated she would expect staff to have identified a resident's vaccine status upon admission so they could be educated and offered the appropriate vaccines.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident Immunizations dated 9/29/23, identified the following:</p> <p>An immunization history will be taken upon admission.</p> <p>The resident's immunization history will be documented and maintained on the immunization record for each resident in the resident's medical record.</p> <p>Any immunizations that are not current or unknown vaccination histories will be shared with the attending physician and appropriate physician orders obtained.</p> <p>The resident or the resident's representative has the opportunity to refuse the immunization.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587</p> <p>Based on observation, interview, and document review the facility failed to ensure resident call lights were within reach from the bathroom floor in multi-resident bathrooms for 5 of 5 residents (R3, R15, R23, R40, R22) reviewed for call light accessibility.</p> <p>Findings include:</p> <p>On 12/12/24 at 8:22 a.m., the following bathroom call lights were observed:</p> <p>room [ROOM NUMBER] call light did not reach the floor, there were several knots in the cord.</p> <p>room [ROOM NUMBER] call light was short approximately 12 inches in length and did not reach the floor.</p> <p>room [ROOM NUMBER] call light was short approximately 15 inches from the floor.</p> <p>room [ROOM NUMBER] call light would not turn on when the cord was pulled.</p> <p>room [ROOM NUMBER] call light was approximately 12 inches in length and did not reach the floor.</p> <p>During an interview on 12/12/24 at 9:43 a.m., nursing assistant (NA)-D stated he thought call light cords in the bathroom had to reach below the toilet. NA-D could not recall any education on the length of the call light cord in bathrooms.</p> <p>During an interview on 12/12/24 at 10:48 a.m., with registered nurses (RN)-A and RN-B neither was aware of any regulations about the length of call lights in resident bathrooms.</p> <p>On 12/12/24 at 12:04 p.m., maintenance director (M)-A went to each room and measured the call light cords:</p> <p>room [ROOM NUMBER] bottom of call light cord was 23 inches from the floor - cord had several knots in it</p> <p>room [ROOM NUMBER] bottom of call light cord was 15 inches from floor - cord had several knots in it</p> <p>room [ROOM NUMBER] call light was not working and M-A had not been made aware of this and had not received any repair requests</p> <p>room [ROOM NUMBER] bottom of call light cord was 20.5 inches from the floor</p> <p>room [ROOM NUMBER] bottom of call light cord was 9 inches from the floor - cord had several knots in it</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/12/24 at 1:36 p.m., the director of nursing (DON) stated it was important to have call lights that reached to the floor in resident bathrooms in case of a fall so they could reach the call light.</p> <p>Call light dated 10/23/17, did not address the length of call lights in resident bathrooms.</p>		