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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Health Center	3910 Minnesota Avenue Duluth, MN 55802

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure they provided sufficient staffing per their facility assessment. In addition, the facility failed to provide sufficient staff to complete timely cares and assistance with checking and changing for 1 of 1 resident (R8) reviewed for activities of daily living and who were dependent on staff for assistance. This had the ability to affect all 36 residents residing in the facility. Findings include: The facility assessment, Franciscan Health Center Staffing Plan Staffing dated 10/23/25, identified the following staffing needs with an average daily census of 39: Licensed nurses providing direct care, every day of the week for AM and PM shift there were two eight-hour positions, and the overnight (NOC) shift had one eight-hour position. Unlicensed staff (NA), every day of the week for AM shift had five eight-hour positions, PM shift had four eight-hour positions, and NOC shift had two eight-hour shifts. During the survey, the following staffing shortages were noted: Monday 2/23/26, AM shift NA total was three from 6:30 a.m. until 12:30 p.m. when a fourth NA was added to the schedule. The resident census was 36. Tuesday 2/24/26, AM scheduled for four NAs. The resident census was 36. Wednesday 2/25/26, scheduled for three NAs. The resident census was 37. Thursday 2/26/26, AM scheduled for four NAs, there was a call-in for AM shift so there was a fourth aid who stayed until 10 a.m., from 10 a.m. to 2:30 p.m., there were three NAs. The resident census was 38. The PBJ Staffing Data Report for fiscal year 25, quarter 4 identified excessively low weekend staffing: 12/6/25, AM NA hours were actually 24, 32 were scheduled 12/7/25, AM NA hours were 16, 32 were scheduled. For PM, actual NA hours were 24 and 32 were scheduled. (continued on next page)

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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/8/25, PM NA hours were 24, 32 were scheduled 12/12/25, NOC NA hours were 16, 24 were scheduled 12/13/25, PM NA hours were 24 after 7 p.m., and 16 after 9 p.m., 40 were scheduled 12/14/25, AM NA hours 24, 32 were scheduled 12/15/25, PM NA hours were 24, 32 were scheduled 12/19/25, AM NA hours were 24, 32 were scheduled 12/20/25, PM NA hours were 24 after 9 p.m., and 16 after 9:30 p.m., 32 were scheduled 12/22/25, PM NA hours were 24 at 7 p.m., 32 were scheduled 12/27/25, PM NA hours were 16 at 10 p.m., 32 were scheduled 12/29/25, AM NA hours were 24, 32 were scheduled. PM NA hours were 24, 32 were scheduled 1/2/26, AM NA hours were actually 24, 32 were scheduled 1/4/26, NOC NA hours actually 8 after 4 a.m., 16 were scheduled 1/11/26, PM NA hours were actually 16 after 6 p.m., 32 were scheduled 1/16/26, PM licensed nurses were actually 8 after 8 p.m., 16 were scheduled 2/6/26, PM NA hours were actually 24 and 32 were scheduled 2/9/26, PM NA hours were actually 24 and 32 were scheduled 2/16/26, AM NA hours were actually 32, 40 were scheduled 2/21/26, AM NA hours were actually 24, 32 were scheduled 2/22/26, AM NA hours were actually 24, 32 were scheduled During the survey from 2/23/26 to 2/27/26, NA-E stated usually they have about 10 residents to care for during the day, but if they were short, it would be more. When they were short, NA-E described tactics like waiting to wash someone's face or brushing their teeth until later in the day or having to do a bed bath instead of a tub bath or shower. In an interview during the survey from 2/23/26 to 2/27/26, RN-E stated they were responsible for medications and treatments for 22 residents. RN-E also stated it was difficult to get it done; one medication pass ran into the next without time between. For example, today they were late with medications and treatments. In an interview during the survey from 2/23/26 to 2/27/26, stated today after 10 a.m., NA-D had 12 or (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13 residents in their group, and that was typical as they were consistently short-staffed. They added the nurse managers were helpful on the weekdays, but on the weekends, there weren't any extra bodies here. NA-D stated they thought most of the important things got done, but they didn't get breaks. All core staff wrote a letter to management about 4 months ago and gave it to all of management and their union and they never heard anything back from anyone. In an interview during the survey from 2/23/26 to 2/27/26, NA-F stated they were responsible for about 14 people. They felt like they could get their work done but didn't have the extra time to do extras like visiting the residents or taking them outside anymore. During an interview on 2/27/26 at 11:52 a.m., facility scheduler (FS)-F stated she put out a two-week schedule a month in advance every month, and there had been times she had to put out a schedule with holes in it despite attempts to fill them with facility casual staff or staffing agency staff. FS-F stated when there was a call-in the NOC nurse starts calling through to fill it and then she would take over when she got to work. The struggle is with call-ins with weekends. They have recently had a large number of call-ins for the weekend and there isn't the support staff here to help out. FS-F considers the nurse managers and MDS coordinator are as staff that is hands-on caregiving because they do help out when they are here and they are always willing to help. During an interview on 2/27/26 at 12:14 p.m., the acting director of nursing (DON) confirmed there were times during the survey where they had call-ins they couldn't replace. Staff didn't really complain about the schedule, they might let the managers know and the managers would then help on the floor. The DON explained they have worked on making sure the care group sheets are fair and equal, have put out suggestion folders for staff to give feedback on the group sheets and shower schedule, and they just had a NA meeting the end of January so they talked about everyone's opinions and thoughts about where things are at currently. Nurse managers do help with things with med cart, help on the floor. There are days when a nurse calls in there are times when they may have to be just passing medications. The nurse managers are on call for the weekends, if there were an emergent staff issue, they would come in. An example would be if there were no RN in the building, or if they only had one or two aids. Self-Care and Activities of Daily Living:See also F677 R8: R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, history of urinary tract infections, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living and was always incontinent of bowel and bladder. A review of R8's current order summary report included the following orders: One half vinegar one half water solution soak two times a day, soak right abdominal groin folds and under both breasts for 10 minutes with solution, pat dry, apply zinc cream, dated 2/26/26. Skin charting one time a day every Saturday complete weekly per schedule, dated 11/22/25. Myrbetriq (medication used to treat overactive bladder) oral tablet extended release 24 hour 60 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	milligrams (mg) one time a day related to stress incontinence, dated 10/11/25. R8's history order summary report included the following orders: Nystatin external powder 100000 unit per gram (GM) apply to affected areas tropically as needed for two times a day apply to abdominal folds, groin, under breasts, dated 10/10/25. Monitor and document signs and symptoms of urinary tract infection and vitals every shift, document in progress notes, started on 1/26/25. R8's care plan dated 10/10/25, identified R8 had an activity of daily living deficit related to activity intolerance, impaired balance. Interventions included a toileting schedule every two to three hours and per their request. The care plan identified frequently incontinent of bowel and bladder. In addition, bowel incontinence related to immobility. Interventions included to check every two hours and assist with toileting as needed. R8's care plan dated 10/10/25, identified R8 was at risk for insomnia. Interventions included to maintain a consistent schedule with daily routine. R8's care plan dated 1/7/26, identified R8's personal care preferences. Interventions included, I prefer to be woken around and be out of bed after 9:00 a.m Do not wake me up before 9:00 a.m A review of R8's weekly skin assessments revealed the following: 2/21/26, moisture documented as normal, noted No, there are no skin concerns. 1/24/26, (about a month earlier) moisture documented as normal, noted No, there are no skin concerns. 1/21/26, moisture documented as normal, noted No, there are no skin concerns. 1/6/26, (about two weeks earlier) documented as other quarterly MDS. Skin group page 18 documented as No skin issues further pages identified perineum, right breast, left breast, rash all documented as resolved. 12/10/25, (about 4 weeks earlier) moisture documented as normal, noted No, there are no skin concerns. 12/2/25, moisture documented as normal, noted No, there are no skin concerns. 11/29/25, moisture documented as normal, noted No, there are no skin concerns. 10/14/25, (about 6 weeks earlier) moisture documented as normal 10/10/25, admission skin assessment, left and right breast, perineum rash, present on admission, chronic greater than 3 months. A review of R8's progress notes revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2/24/26, 3:32 p.m., Writer asked to assess resident skin under breasts and abd (abdominal)/groin folds. Skin condition not improving with current treatment of Nystatin powder. Writer called Dr. XXXXX and received new order as follows: Soak right abdominal/groin folds and under both breasts for 10 minutes with 1/2 vinegar 1/2 water solution. Pat dry. Apply Zinc cream. Twice daily. Writer also discussed adding resident to list for wound care NP to see. 2/10/26, 10:47 a.m., New orders from MD Please keep pt (patient) dry r/t (related to) recurrent UTIs (urinary tract infections). A continuous observation started on 2/25/26 at 7:05 a.m. and ended at 11:01 a.m., four hours. At the beginning of the observation R8's door was closed and the lights in the hallway were dim. No staff were observed going into R8's room during the four-hour window. On 2/25/26 at 11:01 a.m., nursing assistant (NA)-B knocked and entered R8's room. R8 gave permission to observe cares. NA-B left the room to get the nurse for some skin issues. -at 11:15 a.m., registered nurse (RN)-E entered the room, performed hand hygiene, put on gloves and opened R8's brief. R8's skin was bright red in groin area (both sides), extending across her abdomen under pannus (hanging, apron-like layer of skin and fat that sags over the lower abdomen and pubic region). The bright red skin extended from one to four inches in groin and pannus areas. Under R8's breasts the skin was bright red with the redness extending two to three inches under breasts. RN-E told R8 the treatment with nystatin was not working and her provider changed the treatment order, RN-E told her it was a vinegar and water mixture and it might sting. -at 11:28 a.m., R8 was rolled to her left side, the brief was soaked yellow from urine and R8 had a moderate amount of formed brown stool, in her brief and stuck to her skin. R8's skin was intact on her buttocks. A new brief was positioned under R8. -at 11:35 a.m., RN-E returned to finish the treatment process. She removed the 4x4's, dried R8's skin, and put on the new skin treatment, she told R8 what she was doing and asked her if it was hurting. R8 periodically would answer yes or wince. -at 11:43 NA-B asked R8 if she had wanted to be woken up earlier, R8 responded with yes, wake me up. During an interview on 2/23/26 at 1:41 p.m., R8 stated she sometimes had to wait two hours to get the call light answered. R8 stated one night she was left wet all night until the next morning. During an interview on 2/24/26 at 10:25 a.m., R8 was dressed for the day and seated in her wheelchair in her room. R8 stated she liked to get up about 9:00 a.m. During an interview on 2/25/26 at 11:00 a.m., nursing assistant (NA)-B stated R8 had last been checked and changed at 6:30 a.m., by the night shift. NA-B stated she was aware R8 liked to be up around 9:00 a.m. and stated it had been too long to go without checking for incontinence. NA-B stated they were down one nursing assistant and were sometimes short. NA-B stated they were taking care of 14 residents by themselves. During an interview on 2/26/26 at 1:18 p.m., RN-A reviewed R8's care plan and stated R8's preference was to be up after 9:00 a.m RN-A verified four hours was too long to go without checking for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	incontinence and changing a resident's brief. RN-A stated R8 was having moisture related skin concerns, said it might be related to incontinence. RN-A reviewed the note from the provider to keep resident dry related to recurrent urinary tract infections. RN-A stated they had been treating the redness in her groin and under her breasts since October 2025. During an interview on 2/27/26 at 9:40 a.m., RN-A reviewed R8's skin assessments and verified they were being documented as moisture normal and no skin concerns. RN-A verified there were gaps sometimes as long as month with no skin assessment documented as completed. RN-A stated the expectation was skin checks would be completed weekly to monitor skin and keep track of any skin problems. During an interview on 2/27/26 at 10:59 a.m., the acting director of nursing (acting DON) stated it was the expectation the skin checks would be completed weekly on the shower day. The acting DON stated if the resident refused their shower, it was still the expectation the skin checks would be completed. If the resident refused the skin checks the acting DON stated, the expectation would be for the nurse to re-approach and notify the nurse manager of the refusal. The acting DON stated the weekly skin checks were important to look for skin breakdown. The acting DON stated checking and changing was also important to complete as identified in the care plan, again stated the purpose was to prevent skin breakdown. During an interview on 2/27/26 at 1:47 p.m. licensed practical nurse (LPN)-B stated they had finished R8's treatment and noted skin under breasts was pink, in the groin area bright red. LPN-B stated R8's skin looked improved from the previous week. LPN-B stated R8 said it burned a little during the treatment. Skin Integrity dated 5/21/25, identified nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice. In addition, the policy identified skin checks would be completed weekly by a licensed nurse and the provider would be notified of any significant changes or a delay in healing. The policy further identified skin issues would be tracked, trended and reported at the Quality Assurance Performance Improvement meetings to determine if corrective action needed to be taken.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the proper labeling of medications and the removal of expired medications and supplies occurred in one of one medication rooms and one of two medication carts. In addition, the facility failed to ensure the proper storage of resident medications for 1 of 1 resident (R15) that self-administer medications. These deficient practices had the potential to impact all residents who received supplies and medications from reviewed medication rooms and carts.Findings include:During a review of Medication cart A on 2/24/26 at 3:20 p.m., with registered nurse (RN)-C. RN-C confirmed the following findings: Drawer one contained an undated insulin glargine pen for resident (R1). RN-C stated medications like insulin need to be dated when removed from the refrigerator because the expiration date of the medication changed when it moved to room air and most insulins expired after 30 days. RN-C stated R1's insulin pen was unused, but they were unsure when it was removed from the refrigerator because it was not dated. RN-C returned R1's undated insulin pen to the medication cart. Four inhalers in drawer one were reviewed. RN-C confirmed three inhalers were in use but had not been dated when opened and indicated inhalers should be dated when opened.During a review of the medication room on 2/26/26 at 12:12 p.m., with RN-A. RN-A confirmed the following findings: Lower cabinet one, below the sink, contained four boxes of Nestle arginine powder (nutritional protein supplement for human consumption), personal unlabeled electric shavers, four bottles of Clippercide, and cleaning supplies including bleach. RN-A confirmed 3 boxes of the arginine powder expired on 12/15/25 and stated they needed to dispose of the boxes. RN-A indicated they were not sure what the guideline was for storing food products and chemical products together. Lower cabinet two moving left to right contained an intravenous emergency kit (IV E-kit) labeled first drug expired 8/31/23. The IV E-kit included a normal saline IV bag which expired 9/20/23, a dextrose with half normal saline IV bag which expired 8/2023, three heparin syringes which expired 11/30/23, and a Continu-Flo solution set with regulator which expired 7/4/25. RN-A confirmed the expired items in the kit and stated the items needed to be discarded. During an observation and interview on 2/26/26 at 10:02 a.m., licensed practical nurse (LPN)-A unlocked and opened medication cart A and removed R1's insulin glargine pen. LPN-A confirmed R1's insulin pen was undated and indicated that the pen had been partially used. LPN-A removed the insulin pen from the drawer and stated they would get a new pen since they do not know when it was opened.During an interview on 2/26/26 at 1:38 p.m., the acting director of nursing (DON) stated insulin pens should be dated when removed from the refrigerator and if a nurse found a pen that was not dated, they expected the nurse would review the policy and do a calculation for administration. Dating the insulin pen was important because insulin was only good for so long. They stated they did not believe the Nestle Arginine drink mix was normally stored under the sink in the medication room and confirmed concerns about cleaning chemicals and consumables being stored together under the sink. The acting DON stated the facility checked for expired medication and supplies weekly on the night shift. They did not feel staff would use expired supplies but indicated the expired iv kit items and protein supplements would need to be disposed of.A facility conducted inventory of their intravenous emergency kit (IV E-kit) on 2/26/26 found the following items were expired: 4 normal saline (NS) 1-liter (L) intravenous (IV) bags expired 9/2023, 2 half NS L IV bags expired 8/2023, 2 dextrose with half NS L IV bags expired 8/2023, 2 dextrose with half NS and potassium IV bags expired 9/2023, 2 dextrose L IV bags expired 9/2023, 3 heparin pre-filled syringes expired 11/2023, 3 IV start kits expired 5/2024, 3 central line dressing change kits expired 1/2024, 4 22-gauge IV catheters expired 10/1/23, 4 24-gauge IV catheters expired 2/2024, and 3 adapter caps expired 9/2025.The facility provided manufacturer document Insulin Glargine - Insulin Glargine (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Injection Solution dated 3/3/25, the section Instructions for Use directed pens should be thrown away after 28 days if they are stored at room temperature.The facility provided Thrifty [NAME] Pharmacy Services document Insulin Administration - Pen dated 1/2018, directed to document the date open on the pen when it was obtained from the refrigerator.The facility policy Medication, Treatment, and Medical Supplies Storage dated 7/27/16, directed nursing staff to check expiration date prior to utilizing medications, treatment supplies, or medical supplies, and to conduct weekly audits of the medication storage room and medication carts for expired medications, treatment supplies, or medical supplies. Any found to be expired will be disposed of or destroyed, depending on the type of medication, treatment supply, or medical supply.A facility policy on insulin administration and insulin pens was requested but not received.R15:R15's annual Minimum Data Set (MDS) dated [DATE], indicated R15 was cognitively intact.R15's facesheet dated 2/27/26, included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea.R15's care plan last revised 11/24/25, in special instructions, identified self-administration of medication (SAM) of nebulizer treatments after set-up.R15 current provider orders dated 2/27/26, included:Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 3 ml inhale orally every 4 hours as needed for SOB- Spasm of Lung Air Passages Ok to self-administer after set upBudesonide Inhalation Suspension 0.5 MG/2ML (Budesonlde (Inhalation)) 2 ml inhale orally two times a day for Chronic Obstructive Lung Disease Rinse mouth after each use May self-administer after set upIpratroplum-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratroplum-Albuterol) 3 ml inhale orally four times a day for Chronic Obstructive Lung Disease May self-administer after set upNo evidence of orders for Magnesium Citrate 200 mg, Pure ZZZs Melatonin, or Centrum Men's Multivitamin.R15's medication administration record (MAR) dated 2/27/26, instructed that R15 may self-administer the following medications after set-up by the nurse:Budesonide Inhalation Suspension 2 ml inhaled orally two times a day.Albuterol Sulfate Inhalation Nebulization Solution 3 ml inhaled orally every 4 hours as needed.Ipratropium-Albuterol Inhalation Solution 3 ml inhaled orally four times a day.R15's SAM assessment dated [DATE], reported R15 was approved for self-administration of medications, including inhalants and oral medications, and was safe to leave medications at bedside after set-up, but was not capable of storing medications in a secure location and required assistance opening and closing medication containers. During an observation on 2/23/26 at 12:33 p.m., R15 was sitting in a wheelchair in their room completing a nebulizer treatment. There were three supplement bottles in a basket to the right of R15's recliner. Three unopened nebulizer ampules were on the bedside table in front of them. R15 stated they did their own nebulizer treatments.During an observation on 2/24/26 at 11:17 a.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner.During an observation on 2/25/26 at 1:24 p.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner.During an observation on 2/26/26 at 9:53 a.m., R15 was sitting in a wheelchair in their room. One unopened nebulizer ampule was on the bedside table in front of them. Three supplement bottles noted in a basket to the right on R15's recliner. R15 stated they no longer take these vitamins.During an interview on 2/25/26 at 1:55 p.m., RN-B stated medications and nebulizers can be kept at bedside if it is ordered. They stated R15 could self-administer nebulizer treatments after set-up by nurses.During an interview on 2/25/26 at 2:05 p.m., acting DON stated with SAM orders directing staff to set-up nebulizer treatments, staff would fill the nebulizer medication cup and return after treatment was completed to clean it. They stated for a resident to have medications at bedside, a SAM assessment needed to be completed. R15 had a SAM assessment previously which allowed them to set up their own nebulizer and have a small supply at bedside.During an interview on 2/26/26 at 2:44 p.m., RN-A stated for a resident to have medications in their room, a SAM assessment needed to be completed. They confirmed the importance of making (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sure the medications are secured so someone else cannot get them.During an interview on 2/26/26 at 2:57 p.m., the acting DON stated when a resident brought medications, nurses secured them until a SAM assessment was completed. They confirmed medications in a resident room required orders and needed to be secured. The acting DON stated they would not want vitamin bottles stored in R15's room and they were concerned that other residents could get an unsecured medication.During an interview on 2/26/26 at 4:22 p.m., the acting DON confirmed three bottles of gummy vitamins were in R15's room and R15 was not taking them. An inventory was completed with acting DON on the vitamins they removed from R15's room: Magnesium Citrate 200 mg gummies which expired 2/2025, Pure ZZZs Melatonin gummies which expired 6/2025, and Centrum Men's Multivitamin gummies which expired 7/2024.The facility policy Self-Administration of Medication by Residents dated 2/27/24, directed nursing staff to conduct a SAM assessment if a resident wanted to take their own medication. This assessment determined which medications were appropriate to self-administer, where to store the medications, and what assistance the resident needed to actively participate in the administration of their medications.

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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Health Center	3910 Minnesota Avenue Duluth, MN 55802

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure food safety practices were followed during meal preparation. This had the potential to affect all residents who ate food prepared in the kitchen. Findings include:On 2/23/26 at 12:00 p.m., raw chicken was observed in a covered plastic container resting in a sink. Dietary Manager (DM)-D stated the chicken was brining in a solution with lemon and garlic.On 2/23/26 at 12:04 p.m., [NAME] C-A stated the chicken had been thawed in the refrigerator and stated the solution was salt, sugar, thyme, lemons, and water. C-A stated it had been brining for about 30 minutes outside of the refrigerator and would be placed on pans and baked in about 10 minutes.On 2/23/26 at 12:09 p.m., C-A checked the temperature of the brine it was 36.5 degrees Fahrenheit. A chicken breast was checked and the temperature was 32.9 degrees Fahrenheit. C-A stated it would have been better to brine the chicken in the cooler or the refrigerator. A review of the recipe for Lemon-Thyme Brined Chicken from Dining Manager dated 2026, identified the following, Add the chicken to a resealable plastic bag or container with lid; then add in the liquid. Seal the bag and refrigerate for 4 hours (no more than 8hours).Perishable Food Management dated 8/29/22, identified the following, All perishable food will be appropriately managed (cooked, cooled and stored) to prevent bacteria from multiplying or forming toxins. In addition, the policy identified the following, Examples of foods that must be kept refrigerated for safety include meat, poultry, fish, dairy products, and all cooked leftovers.

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	245258	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP) were in place for a resident who had chronic pressure ulcers (PU)s requiring ongoing wound care. This failure had the potential to increase the risk of transmission of multidrug-resistant organisms (MDROs) during high contact resident care activities for 1 of 1 resident (R3) reviewed for wound care. In addition, the facility failed to ensure appropriate infection control was completed during personal cares for 1 of 1 resident (R6) whose cares were observed. The facility also failed to provide appropriate hand hygiene, properly follow EBP precautions, and complete cleaning of shared equipment.Findings include: According to the Centers for Disease Control (CDC)'s web page, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, residents with wounds (including chronic wounds such as pressure injuries, diabetic foot ulcers, and venous stasis ulcers) are considered at increased risk for MDRO transmission and should be cared for using EBP during high-contact care activities. The CDC doesn't define chronic wounds by duration, but rather by presence and need for on-going wound care. R3's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), and severe protein-calorie malnutrition. The MDS identified R3 was at risk for and had actual pressure ulcers including a stage three and an unstageable deep tissue injury. R3 had a functional limit in range of motion of the upper and lower body on one side and was dependent with toilet hygiene, lower body dressing, transfers, and needed maximum assistance with bed mobility. R3's medication administration record (MAR) for the month of February 2026, identified wound care was provided daily to R3's foot and hip. R3's provider orders dated 2/27/26 didn't identify an order for EBP. R3's care plan contained an undated banner message on the first page titled Special Instructions which contained in part the following information, EBP related to wound, with no further details or instructions. The care plan didn't contain a focus statement for impaired skin integrity or wounds. A document, Integrated Wound Care (IWC) dated 12/3/25, identified R3 was evaluated and diagnosed with a stage three pressure ulcer of the right foot fifth interdigital space. The wound measured one centimeter (cm) by one centimeter, with heavy serous drainage, and a wound bed of 50% slough (dead or damaged tissue) and 50% granulation (new, healthy tissue). A second IWC document dated 1/5/26, identified R3 was evaluated and diagnosed with an unstageable deep tissue injury to the right lateral hip measuring two cm by two cm, with moderate serosanguineous drainage, and 100% slough tissue. During an observation on 2/26/26 at 10:47 a.m., registered nurse case manager (RNCM) with hospice and nursing assistant (NA)-D provided wound care to R3 without donning gowns. There wasn't a personal protective equipment (PPE) station in the room, nor was there a sign on R3's door indicating EBP was in place. During an interview on 2/26/26 at 1:32 p.m., the acting director of nursing (DON) stated they would (continued on next page)

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	02/27/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use EBP for a chronic wound, and a chronic would be something present three months or longer or are not healable or resolved. They have discussed R3 and EBP, but they decided they weren't to that threshold yet. A policy, Enhanced Barrier Precautions dated 8/20/24, identified its purpose was to provide guidelines to staff in the application of EBP to safely care for residents colonized or infected with MDROs. EBPs shall be used when providing high contact care to residents who are colonized or are infected with an MDRO when contact or other precautions do not apply. EBP should also be used for residents with chronic wounds and/or indwelling medical devices (e.g., urinary catheters, feeding tubes, central line, tracheostomy). Chronic wounds are defined as pressure ulcer, diabetic foot ulcer, unhealed surgical wound, and venous stasis ulcer. Skin breaks or skin tears are not considered a chronic wound. High-contact resident care activities included wound care, dressing, bathing, showering, changing linen, hygiene care, toileting care. R6: Review of R6's quarterly MDS dated [DATE], identified R6 as moderately cognitively impaired. R6's facesheet included diagnoses of stage 4 pressure ulcer (PU4) left buttock, congestive heart failure (CHF), and venous insufficiency. R6's care plan revised 11/24/25, instructed: R6 required assistance of two when repositioned and when transferred with full sling mechanical lift use Enhanced Barrier Precautions (EBP) monitor dressing to ensure it is intact and adhering and report lose dressing to treatment nurse provide skin care per facility guidelines wound care per treatment order of specialized practitioner for wound management R6's provider orders dated 2/27/26 included: PU (pressure ulcer) to left buttock: as needed for If dressing soiled, came off during cares/shower etc Staff to use foot cradle in bed. Encourage Frequent offloading Q 2hrs (every 2 hours) and up in chair daily for 2 hrs. PU to left buttock: every evening shift related to pressure ulcer of left buttock, stage 4 WC (wound care) to wound bed, 1/4 strength Dakins packing (apply kerlex gauze and pack wound), cover with bordered foam to secure daily and prn (as needed), Encourage frequent offloading every 2 hours and up to chair daily for 2 hours. Pressure Ulcer L-heel every day shift every other day Wound cleaner, collagen sprinkles to wound bed, apply barrier swab to peri wound, and border foam to cover QOD (every other day) and PRN (as needed). Off load pressure. Pressure Ulcer L-heel as needed for as needed Wound cleaner, collagen sprinkles to wound bed, apply (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	barrier swab to peri wound, and border foam to cover QOD (every other day) and PRN (as needed). Off load pressure. R6's Integrated Wound Care (IWC) progress notes dated 2/23/26 identified pressure wounds to left buttock, left heel, and right ankle. It also identified frequent incontinence of bowel and bladder results in difficulty with healing. R6's treatment administration record (TAR) dated 2/27/26, instructed staff to: provide wound care to left buttock PU4 every evening shift, packing the wound and covering with bordered foam to secure daily and as needed if soiled or change off in shower etc. monitor left buttock PU4 daily and create a progress note provide wound care to left heel PU every day shift every other day and as needed During an observation on 2/25/26 at 12:49 p.m., NA-A entered R6's room. R6's door had an EBP sign on the door. NA-A wearing gloves, but no gown, straightened R6's bedding and adjusted a lift sling around R6 as they sat in their wheelchair. Registered nurse (RN)-B with gloves but no gown arrived to assist NA-A with using a mechanical full sling lift to transfer R6 from wheelchair to bed. NA-A and RN-B put on gowns and changed R6's brief. NA-A removed PPE, (did not sanitize hands), adjusted blankets, elevated R6's ankles, moved bedside table, opened blinds, and exited R6's room without hand sanitizing. NA-A left mechanical lift outside R6's door and took the trash to dirty utility room. They unlocked dirty utility room, disposed of trash, and washed hands. NA-A did not return to sanitize the mechanical lift. During an interview on 2/25/26 at 2:28 p.m., NA-A confirmed they had not gowned for transferring R6 from wheelchair to bed, had not hand sanitized after removing gloves before touching R6's personal items, had not sanitized before exiting R6's room, and had not sanitized the mechanical lift after use. They confirmed the EBP sign on R6's door. They stated they should have done these steps for proper infection control. During an observation on 2/26/26 at 9:02 a.m., licensed practical nurse (LPN)-A was in R6's room, in gown and gloves, changing right ankle dressing and left heel dressing. They had completed the right ankle dressing change, changed gloves without hand sanitizing, removed left heel dressing and cleansed the wound, changed gloves without hand sanitizing, put wound cleanse spray in bin, and applied clean dressing to left heel. LPN-A removed PPE, hand sanitized, and left R6's room. LPN-A returned to R6's room with NA-A, both gloved but did not gown, and repositioned R6. During an interview on 2/26/26 at 10:02 a.m., LPN-A confirmed they should have sanitized hands with glove changes during dressing change. They stated hand sanitizing is important for infection control especially between removing the soiled dressing and applying a new dressing. They also confirmed R6 was on EBP and stated the sign on R6's door indicated gowning for transfers and dressing changes, but they were unsure about repositioning. During an interview on 2/26/26 at 2:57 p.m., acting DON stated they expected staff to perform proper hand sanitizing between residents, after cares, when moving from dirty dressing to clean dressing, and when hands were visibly soiled. They stated it was important to protect residents from further infection with EBP, and they expected staff to follow EBP door signs. Staff should wear PPE for (continued on next page)

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	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfers, position changes, and close cares. They also expected staff to sanitize shared equipment after each use. A facility provided Enhanced Barrier Protection sign, received 2/26/26, instructed staff to wear gloves and a gown for high-contact resident care activities, including dressing, transferring, changing briefs, and wound care. A facility policy Enhanced Barrier Protection dated 8/20/24, instructed staff to use EBP for high-contact cares including when briefs were changed, when wound care was performed, and when residents were dressed, bathed, and transferred. A facility policy Hand Hygiene revised 1/21/25, instructed staff to perform handwashing or hand sanitizing before and after direct contact with a resident, when moving from a contaminated body site to a clean body site during resident care, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident, and after removing gloves or gowns. A facility policy Cleaning Disinfecting Resident Care Equipment revised 1/25/22, instructed staff to disinfect mechanical lifts after each use. Staff were to use a disinfectant wipe to clean areas that came in contact with the resident and use a second disinfectant wipe to disinfect these areas.

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	245258	A. Building B. Wing	02/27/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy of the minimum data set (MDS) was coded accurately for 3 of 14 residents (R3, R12, R15) reviewed for MDS accuracy. Findings include: R3: R3's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition. The MDS identified R3 was at risk for and had actual PUs including a stage three and an unstageable deep tissue injury, both were identified as present on admission. R3's quarterly MDS dated [DATE], identified R3 was at risk for and had an actual stage three pressure ulcer (PU) that was not present on admission. R3's admission MDS dated [DATE], identified R3 was not at risk for and didn't have any actual PUs. Further, the MDS identified a formal assessment tool (i.e., Braden Scale) was not performed. R3's care area assessment (CAA) dated 9/22/25, identified the pressure ulcer care area and care planning decision were triggered. R3's care plan didn't contain a focus statement for at-risk or actual skin impairment. On 9/19/25, R3's care plan had a focus statement for activities of daily living (ADL) self-care performance deficit related to CVA with an intervention for staff assist of one to turn and reposition every two hours and as needed and preferred not to be woken at night. A Braden Scale for Predicting Pressure Sore Risk performed on 9/19/25, identified R3's score was 17, which correlated to an at-risk category. The wound portal in R3's electronic medical record (EMR) identified a new in-house acquired stage three pressure ulcer at the right dorsum, fourth interdigital space on 12/10/25. A new in-house acquired unstageable pressure injury to the front right trochanter (hip) on 1/7/26. During an interview on 2/26/26 at 3:57 p.m., registered nurse (RN)-D stated they were the MDS nurse, and she would say the information in section M of the 2/6/26 MDS was an error. RN-D stated the error would affect reimbursement. R12: R12's significant change MDS dated [DATE], identified R12 had diagnoses which included malignant neoplasm of right renal pelvis, hypothyroidism, dementia, and hypertension. In addition, R12's MDS identified they were severely cognitively impaired. Section N Medications: High-Risk Drug Classes: Use and Indication Antipsychotic: is taking, this was marked as yes. The section Did the resident receive antipsychotic medications since admission/entry or reentry or (continued on next page)

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	245258	A. Building B. Wing	02/27/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the prior OBRA assessment, whichever is more recent? This was marked as not necessary, marked as not on an antipsychotic. R12's current order summary identified the following: Observe closely for side effects of antipsychotic medication dated 10/27/25. Olanzapine (an atypical antipsychotic medication) 15 milligrams (mg) dated 1/13/26 R12's care area assessment dated [DATE], identified the following: Section N-Medications N0415, identified R12 was taking an antipsychotic Section N- Medications N0450, identified R12 was receiving antipsychotics on a routine basis only. It was marked as no a gradual dose reduction had not been attempted. During an interview on 2/25/26 at 1:31 p.m., registered nurse (RN)-D reviewed the MDS dated [DATE], and verified it contained contradictory information. RN-D stated it was a glitch and the MDS would need to be modified. RN-D verified it was important to ensure accuracy for pharmacy review to ensure the need for the medication and to monitor if it was working. R15: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2025, identified Section O0110G3: Non-invasive Mechanical Ventilator – CPAP, code any type of CPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously throughout the breathing cycle. R15's annual Minimum Data Set (MDS) dated [DATE], indicated R15 was cognitively intact. Section O: Special Treatments, Procedures, and Programs, question O0110G3 identified R15 had not received CPAP in the last 14 days. R15's facesheet included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea. R15's care plan revised 11/24/25, included CPAP settings. R15's current provider orders dated 2/27/26, included: CPAP: staff to set up at HS (bedtime) and when in bed for naps. every shift Startup CPAP as machine is preprogrammed and will adjust to inhalation pressure needs R15's treatment administration record (TAR) for the months of 12/2025, 1/2026, and 2/2026 instructed staff to set up the CPAP nightly and as needed for naps. Staff documented daily use of CPAP for the 3 months reviewed. During an interview on 2/23/26 at 12:33 p.m., R15 stated they used their CPAP every night. (continued on next page)

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	02/27/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/26 at 11:03 a.m., RN-D reviewed the MDS dated [DATE], and confirmed it did not contain coding for R15's use of CPAP. They stated it should be coded if the resident is using it. After reviewing R15's record, RN-D confirmed that the CPAP should have been coded on the MDS. A facility policy MDS 3.0 Completion dated 8/20/24, instructed that all MDS item sections were to be reviewed to develop an interdisciplinary care plan. The MDS Coordinator was responsible for conducting audits to identify errors to ensure accuracy of information, and they needed to sign and date the assessment upon completion.

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	245258	A. Building B. Wing	02/27/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure an OBRA Level II evaluation was completed as identified on the pre-admission screening to ensure mental health needs were appropriately addressed or provided for 1 of 1 resident (R8) reviewed for preadmission screening and resident review (PASRR).Findings include:R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living.R8's corrected preadmission screening dated 10/14/25, identified they required an OBRA Level II screening for mental illness. The question, Is an OBRA Level II referral needed and is the person currently seeking admission to a nursing facility? The question was answered as yes.During an interview on 2/24/26 at 10:44 a.m., social service designee (SSD)-A stated R8 came from a different facility. SSD-A stated she was not sure if an OBRA Level II was completed and would check. The facility was not able to provide evidence this was completed prior to admission, nor was there evidence this was completed after admission to the facility.During an interview on 2/27/26 at 11:01 a.m., the acting director of nursing (ADON) stated they were not familiar with the OBRA Level II process and would defer this to the SSD.Pre-admission Screening & Resident Review (PASRR) dated 6/25/24, identified the following, If a mental illness or development disability is identified, an additional screening, referred to as a PASRR Level II screening is required.

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	245258	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Health Center	3910 Minnesota Avenue Duluth, MN 55802

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the plan of care to reflect changes in resident's needs related to the risk of, and actual, skin impairment, to reflect interventions after a fall, to reflect current elopement risk and interventions, to individualize pain management, and to accurately reflect the resident's current mobility status for 1 of 13 residents (R3) reviewed for care planning timing and revision.Findings include:R3's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], was performed following a hospice admission on [DATE], and identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side, cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition, a stage three pressure ulcer, and an unstageable deep tissue wound. R3 had a functional limit in range of motion upper and lower body on one side and was dependent with toilet hygiene, lower body dressing, and transfers. R3 needed maximal assistance with bed mobility and set-up assistance to wheel themselves in a wheelchair for 50 and 150 feet. The MDS also reflected R3 had a wander or elopement alarm used daily.R3's care plan identified:-a revision on 2/20/26, identified a focus statement for risk for falls with interventions dated 9/19/25 to assist resident with ambulation and transfers utilizing therapy recommendations, to determine resident's ability to transfer, and if resident is a fall risk, initiate fall precautions.-a revision on 2/20/26, a focus statement for limited physical mobility related to stroke with interventions dated 9/18 and 9/19/25, to utilize foot pedals on the right side of the wheelchair only to and from destinations; resident able to propel the wheelchair with his left foot, to work on ambulation with therapy only at this time, assist with propelling wheelchair as needed, and to monitor, document, and report any signs or symptoms of immobility, contractures, thrombus formation, skin breakdown or fall-related injury.-a revision on 2/20/26, a focus statement for at risk for falls related to gait and balance problems with interventions dated 9/15/25 to ensure call light in reach and encouragement to use the call light, to educate resident, family and caregivers about safety reminders and what to do if a fall occurs, to encourage resident to participate in activities that promote exercise, physical activity for strengthening and mobility improvement, to ass fall risk quarterly and with changes in condition, to provide resident with easy access to a urinal, provide verbal cues and reminders as needed, and for physical therapy as ordered or as needed. On 11/14/25, the interventions were updated to include ensuring resident had a large, covered mug with fresh water in room in the morning, bedtime, and as needed. On 1/14/26, an intervention to offer to get R3 up for the day at around 7:30 a.m. The care plan didn't contain an intervention for the fall of 2/22/26.-a revision on 2/20/26, a focus statement for acute and chronic pain with interventions dated 11/8/25 to determine resident's satisfactory pain level, to evaluate mood and behavior, and to monitor for factors or activities that precipitate or aggravate pain.-R3's care plan didn't contain a focus statement, goals or interventions for wandering, elopement and the use of an elopement alarm.-R3's care plan didn't contain a focus statement, goals or interventions for actual skin impairment.An elopement assessment dated [DATE], identified R3 wasn't physically immobile, did display wandering and hovering around exits, and made statements of wanting to go home. A wander guard was placed on 9/15/25.An elopement assessment dated [DATE], identified R3 didn't have a wander guard in place as resident was unable to propel himself in his wheelchair and was not at risk for elopement at this time.R3's electronic medical record (EMR) identified post-fall evaluations on 11/8/25, 1/3/26, and 2/22/26.During an observation on 2/23/26 at 2:20 p.m., R3 had a non-removable white bracelet on the left wrist.During an observation on 2/26/26 at 10:47 a.m., nursing assistant (NA)-B confirmed the device on R3's left wrist was a wander guard.During an interview on 2/27/26 at 12:46 p.m., the director of nursing (DON) stated her expectation would be for the care plan to reflect R3's needs.A policy, Person Centered Care Planning dated 4/20/23, identified the facility will develop a (continued on next page)

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	02/27/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive person-centered care plan with the resident and/or family representative for each resident in our care center, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The plan of care will describe the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.b. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment, and any alternative means to address the need.c. Management of risk factors and prevent avoidable declines in functioning.The resident's care plan is reviewed every 90 days or more frequently if necessary, with a significant change. Care plans are updated on an ongoing basis as needed based on changes that occur between care conferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and document review the facility failed to provide timely assistance with checking and changing for 1 of 1 resident (R8) reviewed for activities of daily living and who were dependent on staff for assistance.Finding include:R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, history of urinary tract infections, and post-traumatic stress disorder (PTSD). In addition, R8 was cognitively intact and required substantial to maximum assistance with activities of daily living and was always incontinent of bowel and bladder.A review of R8's current order summary report included the following orders:One half vinegar one half water solution soak two times a day, soak right abdominal groin folds and under both breasts for 10 minutes with solution, pat dry, apply zinc cream, dated 2/26/26.Skin charting one time a day every Saturday complete weekly per schedule, dated 11/22/25.Myrbetriq (medication used to treat overactive bladder) oral tablet extended release 24 hour 60 milligrams (mg) one time a day related to stress incontinence, dated 10/11/25.R8's history order summary report included the following orders:Nystatin external powder 100000 unit per gram (GM) apply to affected areas tropically as needed for two times a day apply to abdominal folds, groin, under breasts, dated 10/10/25.Monitor and document signs and symptoms of urinary tract infection and vitals every shift, document in progress notes, started on 1/26/25.R8's care plan dated 10/10/25, identified R8 had an activity of daily living deficit related to activity intolerance, impaired balance. Interventions included a toileting schedule every two to three hours and per their request. The care plan identified frequently incontinent of bowel and bladder. In addition, bowel incontinence related to immobility. Interventions included to check every two hours and assist with toileting as needed.R8's care plan dated 10/10/25, identified R8 was at risk for insomnia. Interventions included to maintain a consistent schedule with daily routine.R8's care plan dated 1/7/26, identified R8's personal care preferences. Interventions included, I prefer to be woken around and be out of bed after 9:00 a.m. Do not wake me up before 9:00 a.m.A review of R8's weekly skin assessments revealed the following:2/21/26, moisture documented as normal, noted No, there are no skin concerns.1/24/26, (about a month earlier) moisture documented as normal, noted No, there are no skin concerns.1/21/26, moisture documented as normal, noted No, there are no skin concerns.1/6/26, (about two weeks earlier) documented as other quarterly MDS.Skin group page 18 documented as No skin issues further pages identified perineum, right breast, left breast, rash all documented as resolved.12/10/25, (about 4 weeks earlier) moisture documented as normal, noted No, there are no skin concerns.12/2/25, moisture documented as normal, noted No, there are no skin concerns.11/29/25, moisture documented as normal, noted No, there are no skin concerns.10/14/25, (about 6 weeks earlier) moisture documented as normal10/10/25, admission skin assessment, left and right breast, perineum rash, present on admission, chronic greater than 3 months.A review of R8's progress notes revealed the following:2/24/26, 3:32 p.m., Writer asked to assess resident skin under breasts and abd (abdominal)/groin folds. Skin condition not improving with current treatment of Nystatin powder. Writer called Dr. XXXXX and received new order as follows: Soak right abdominal/groin folds and under both breasts for 10 minutes with 1/2 vinegar 1/2 water solution. Pat dry. Apply Zinc cream. Twice daily. Writer also discussed adding resident to list for wound care NP to see.2/10/26, 10:47 a.m., New orders from MD Please keep pt (patient) dry r/t (related to) recurrent UTIs (urinary tract infections).A continuous observation started on 2/25/26 at 7:05 a.m. and ended at 11:01 a.m., four hours. At the beginning of the observation R8's door was closed and the lights in the hallway were dim. No staff were observed going into R8's room during the four-hour window.On 2/25/26 at 11:01 a.m., nursing assistant (NA)-B knocked and entered R8's room. R8 gave permission to observe cares. NA-B left the room to get the nurse for some skin issues.-at 11:15 a.m., registered nurse (RN)-E entered the room, performed hand hygiene, put on gloves and opened R8's brief. R8's (continued on next page)

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	245258	A. Building B. Wing	02/27/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin was bright red in groin area (both sides), extending across her abdomen under pannus (hanging, apron-like layer of skin and fat that sags over the lower abdomen and pubic region). The bright red skin extended from one to four inches in groin and pannus areas. Under R8's breasts the skin was bright red with the redness extending two to three inches under breasts. RN-E told R8 the treatment with nystatin was not working and her provider changed the treatment order, RN-E told her it was a vinegar and water mixture and it might sting.-at 11:28 a.m., R8 was rolled to her left side, the brief was soaked yellow from urine and R8 had a moderate amount of formed brown stool in her brief and stuck to her skin. R8's skin was intact on her buttocks. A new brief was positioned under R8.-at 11:35 a.m., RN-E returned to finish the treatment process. She removed the 4x4's, dried R8's skin, and put on the new skin treatment, she told R8 what she was doing and asked her if it was hurting. R8 periodically would answer yes or wince.-at 11:43 NA-B asked R8 if she had wanted to be woken up earlier, R8 responded with yes, wake me up.During an interview on 2/23/26 at 1:41 p.m., R8 stated she sometimes had to wait two hours to get the call light answered. R8 stated one night she was left wet all night until the next morning.During an interview on 2/24/26 at 10:25 a.m., R8 was dressed for the day and seated in her wheelchair in her room. R8 stated she liked to get up about 9:00 a.m.During an interview on 2/25/26 at 11:00 a.m., nursing assistant (NA)-B stated R8 had last been checked and changed at 6:30 a.m., by the night shift. NA-B stated she was aware R8 liked to be up around 9:00 a.m. and stated it had been too long to go without checking for incontinence. NA-B stated they were down one nursing assistant and were sometimes short. NA-B stated they were taking care of 14 residents by themselves.During an interview on 2/26/26 at 1:18 p.m., RN-A reviewed R8's care plan and stated R8's preference was to be up after 9:00 a.m. RN-A verified four hours was too long to go without checking for incontinence and changing a resident's brief. RN-A stated R8 was having moisture related skin concerns, said it might be related to incontinence. RN-A reviewed the note from the provider to keep resident dry related to recurrent urinary tract infections. RN-A stated they had been treating the redness in her groin and under her breasts since October 2025.During an interview on 2/27/26 at 9:40 a.m., RN-A reviewed R8's skin assessments and verified they were being documented as moisture normal and no skin concerns. RN-A verified there were gaps sometimes as long as month with no skin assessment documented as completed. RN-A stated the expectation was skin checks would be completed weekly to monitor skin and keep track of any skin problems.During an interview on 2/27/26 at 10:59 a.m., the acting director of nursing (acting DON) stated it was the expectation the skin checks would be completed weekly on the shower day. The acting DON stated if the resident refused their shower, it was still the expectation the skin checks would be completed. If the resident refused the skin checks, the expectation would be for the nurse to re-approach and notify the nurse manager of the refusal. Weekly skin checks were important to look for skin breakdown. The acting DON stated checking and changing was also important to complete as identified in the care plan, again stated the purpose was to prevent skin breakdown.During an interview on 2/27/26 at 1:47 p.m. licensed practical nurse (LPN)-B stated they had finished R8's treatment and noted skin under breasts was pink, in the groin area bright red. LPN-B stated R8's skin looked improved from the previous week. LPN-B stated R8 said it burned a little during the treatment.Skin Integrity dated 5/21/25, identified nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice. In addition, the policy identified skin checks would be completed weekly by a licensed nurse and the provider would be notified of any significant changes or a delay in healing. The policy further identified skin issues would be tracked, trended and reported at the Quality Assurance Performance Improvement meetings to determine if corrective action needed to be taken.

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	245258	A. Building B. Wing	02/27/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a wound bed was protected in a resident at risk for cross contamination due to incontinence for 1 of 1 resident (R6) whose cares were observed.Findings include:Review of R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 as moderately cognitively impaired.R6's face sheet, undated, included diagnoses of stage 4 pressure ulcer left buttock, congestive heart failure (CHF), and venous insufficiency.R6's care plan revised 11/24/25, instructed the following:R6 required assistance of two when repositioned and when transferred with full sling mechanical liftuse Enhanced Barrier Precautionsmonitor dressing to ensure it is intact and adhering and report lose dressing to treatment nurseprovide skin care per facility guidelineswound care per treatment order of specialized practitioner for wound managementR6's current provider orders dated 2/27/26 included:PU (pressure ulcer) to left buttock: as needed for if dressing soiled, came off during cares/shower, etc. Staff to use foot cradle in bed. Encourage Frequent offloading Q 2hrs (every 2 hours) and up in chair daily for 2 hrs.PU to left buttock: every evening shift related to pressure ulcer of left buttock, stage 4 WC (wound care) to wound bed, 1/4 strength Dakins packing (apply kerlex gauze and pack wound), cover with bordered foam to secure daily and prn (as needed), Encourage frequent offloading every 2 hours and up to chair daily for 2 hours.R6's Integrated Wound Care (IWC) progress notes dated 2/23/26, identified pressure wounds to left buttock, left heel, and right ankle. It also identified frequent incontinence of bowel and bladder results in difficulty with healing.R6's treatment administration record (TAR) dated 2/27/26, instructed staff to provide wound care to left buttock wound every evening shift, packing the wound and covering with bordered foam to secure daily and as needed if soiled or change off in shower etc.During an observation on 2/25/26 at 12:49 p.m., nursing assistant (NA)-A and registered nurse (RN)-B changed R6's brief. NA-A told RN-B that R6 had no dressing on their left buttock wound. RN-B motioned to continue with brief change. The wound had packing and the brief was saturated, no stool, and there was a baseball-sized amount of light yellow-brown drainage where brief aligned wound. NA-A cleansed R6's skin and replaced their brief. No dressing was applied to the left buttock wound.During an interview on 2/25/26 at 1:55 p.m., RN-B confirmed that R6's left buttocks wound dressing was not in place when they changed R6's brief. They stated they would need to check the order as orders may have changed, and they thought a previous order was to keep the wound open to air. They stated they would review the orders and either do the dressing before the end of their shift or pass it on to the next nurse as a priority.During an interview on 2/25/26 at 3:28 p.m., licensed practical nurse (LPN)-A stated R6's uncovered left buttock wound was passed off to them during shift report from RN-B. They stated they planned to replace the dressing in a few hours but had other priorities first. LPN-A reported that R6 often had multiple stool incontinence episodes per shift. They confirmed concern for infection prevention with the wound being open to the brief.During an interview on 2/26/26 at 2:57 p.m., acting director of nursing (DON) stated they expected staff to notify the nurse if there was no dressing on a wound, and they expected nurses changed dressings as needed for soiled or excessive drainage. Acting DON confirmed their concern for infection control because R6's incontinence of bowel and bladder put them at risk for contamination of the wound bed.The facility policy Skin Integrity revised 5/21/25, directed staff to evaluate the status of the wound dressing and notify the nurse manager if the dressing was not intact or drainage was present.

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	245258	A. Building B. Wing	02/27/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ongoing skin inspections, wound assessments, and timely repositioning were performed for a resident with pressure ulcers for 1 of 2 residents (R3) reviewed for pressure ulcer care. These failures resulted in the development of facility-acquired pressure ulcers and placed the resident at risk for worsening skin breakdown and infection.Findings include:R3's significant change in status assessment (SCSA) minimum data set (MDS) dated [DATE], identified a decline in cognition and diagnoses of hemiplegia and hemiparesis of the right side related to a cerebral vascular accident (CVA, a stroke), severe protein-calorie malnutrition, a stage three pressure ulcer, and an unstageable deep tissue wound. R3 had functional limit in range of motion of the upper and lower body on one side and was dependent for toilet hygiene, lower body dressing, and transfers. R3 needed maximal assist with bed mobility. R3 was admitted to hospice on 1/30/26.Review of R3's care plan revealed a focus statement for activities of daily living (ADL)s dated 2/20/26, which instructed staff to turn and reposition R3 every two hours and as needed. R3 preferred not to be woken at night. The care plan included a focus statement for limited mobility related to CVA dated 2/20/26, which instructed staff to report skin breakdown. However, the care plan didn't have a focus statement for being at risk for or having actual skin breakdown or interventions to monitor and assess the wounds. Review of R3's electronic medical record (EMR) identified the following timeline:9/15/25, admission to facility9/18/25, a Skin and Wound Assessment identified no skin concerns.From 9/19/25 to 11/7/25, R3's EMR didn't contain evidence of skin checks or assessments.11/8/25, a Skin and Wound Assessment identified no skin concerns.11/12/25, a Skin and Wound Assessment identified a new wound with no detail provided.From 11/13 to 11/25/25, R3's EMR didn't contain evidence of skin checks or assessments.11/14/25, a provider order for clotrimazole (a topical antifungal medication used to treat fungal infections) cream to right foot fourth and fifth digit three times per day for two weeks. Ensure you wash and dry area completely before applying clotrimazole.11/26/25 at 5:39 a.m., a progress note: skin warm and dry, skin color within normal limits, and turgor is normal.11/26/25 at 3 p.m., a provider order for skin charting one time a day every Wednesday using assessment, N Adv Skin Check.11/26/25, a N Adv Skin Check identified a wound issue with no detail provided.11/26/25 at 3:53 p.m., a progress note: resident has been refusing clotrimazole (a topical antifungal medication used to treat fungal infections) to right foot according to staff. During cares today, resident had redness, swelling, and foul smell. On-call provider updated and sent a request for oral antibiotics. Will await response.11/26/25 at 5:23 p.m., a progress note: provider responded no oral antibiotic at this time. Provider to see him on next rounds and provided an order to soak foot and dry well once daily and will send a new order for spray clotrimazole to foot for seven days.11/26/25, a provider order to soak right foot in warm soapy water daily. Ensure that foot is dried thoroughly before redressing. Apply clotrimazole aerosol spray between toes on both feet topically two times a day for infection.11/27/25 3:03 a.m., a progress note: athlete's foot to bilateral feet in between toes being treated with clotrimazole aerosol spray two times per day. Foot soaks with Epsom salts at bedtime prior to clotrimazole application.11/27/25 at 9:41 p.m., a progress note: writer inspected resident's toe today and it appeared infected. It had an open area approximately three-quarters of a centimeter (cm) long by one cm wide. The area appeared red and had a yellowish pus coming out of it. Writer cleaned and dressed it per house standing orders. SBAR (a type of communication) placed in rounding book to update provider.12/1/25, a provider visit summary identified resident complained of pain over the right fifth toe due to the ulcer.12/1/25, a provider order for doxycycline 100 mg give one tablet two times a day for infection of the toe for 7 days until finished for 14 doses.12/2/25, a visit summary from Integrated Wound Care (IWC) identified R3 was evaluated and diagnosed with a stage three pressure ulcer of the right foot fifth interdigital space. The wound measured 1 centimeter (cm) (continued on next page)

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	245258	A. Building B. Wing	02/27/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by 1 centimeter, with heavy serous drainage, and a wound bed of 50% slough (dead or damaged tissue) and 50% granulation (new, healthy tissue).From 11/28/25 to 12/9/25, R3's EMR didn't contain evidence of skin checks or wound assessments performed by facility.12/10/25, EMR wound portal entry: new, in-house acquired stage three pressure ulcer at the right fourth interdigital toe space, full-thickness tissue loss measuring 1 cm by 1 cm.12/16/26, N Adv Skin Check with issue noted, didn't provide detail and directed reader to see wound portal.From 12/17/25 to 12/29/25, R3's EMR didn't contain evidence of skin checks or assessments by facility or by IWC.12/29/25, a visit summary from IWC for toe wound.1/5/26, a visit summary from IWC identified R3 was evaluated and diagnosed with a pressure ulcer of the right hip, unstageable, and measured two cm by two cm, with moderate serosanguineous drainage, and 100% slough tissue.1/7/26, EMR wound portal entry: new, in-house acquired unstageable pressure ulcer on the right lateral hip measuring 1.93 cm by 2.32 cm.1/12/26, a visit summary from IWC identified right hip wound was 100% slough and too painful to debride. IWC provided education regarding the need for repositioning.1/12/26, EMR wound portal, a facility assessment for the hip and toe.From 1/13 to 1/23/26, R3's EMR didn't contain evidence of a wound assessment.1/13/26, provider orders for right foot fifth digit: every evening shift for wound, cleanse with wound cleanser. Apply stock antibiotic ointment, cut a piece of calcium alginate with silver to fit wound bed, cover with bordered gauze daily and as needed.1/14/26, provider orders for skin charting every evening shift on Tuesdays for shower day. Go to assessments and start form N ADV Skin Check.1/23/26, EMR wound portal, a facility assessment for the hip and toe.1/26/26 a visit summary from IWC identified sharp debridement was performed on the right hip to remove slough.From 1/27 to 2/9/26, R3's EMR didn't contain evidence of a wound assessment.2/6/26, a provider order for lying and sitting tissue tolerance to be discontinued when completed. Evidence of tissue tolerance testing wasn't located in R3's EMR.2/9/26, IWC visit2/17/26, a provider order for pressure injury right lateral hip, wash with normal saline, apply Vaseline and bordered foam, change daily and as needed. 2/17/26, a provider order for pressure injury right lateral hip, clean with wound cleanser, apply Vaseline and bordered foam, change daily and as needed.During a continuous observation on 2/25/26 from 10:02 a.m. to 12:12 p.m., R3 was observed in the main dining room. At 10:02 a.m., R3 was asleep, leaning to the right in a Broda chair, with his right shoulder and knee lower than the left. There was a tray table in front and slightly to the right of R3, with three bowls and two cups with straws in them. At 10:42 a.m., RN-A straightened up R3's blankets and adjusted his baseball cap. At 10:48 a.m., the dietary manager (DM)-D came to his table and removed the bowls and left the cups. At 11:25 a.m., R3 has gotten a new tray of food placed on his table at his right side, he is using his left hand to feed himself. At 11:31 a.m., DM-D came by and straightened the table closer to his center and then arranged the bowls of food. At 11:45 a.m., NA in blue pants and green top came by and asked R3 if he was struggling and proceeded to hold the ice cream cup for him to take a couple bites. NA then walked away and set the ice cream cup on R3's tray on the opposite side he was eating from. At 12:12 p.m., nursing assistant (NA)-A wheels R3 from the dining room to his room. R3 was heard telling NA-A he wasn't ready to lay down yet, to which NA-A responded for him just to let her know when he was ready. R3 remained in the Broda chair leaning to his right, with his left foot off the footrest. During an interview on 2/25/26 at 2:02 p.m., NA-A stated R3 was in her group today and she thought he needed to be repositioned every two hours she knew he should've been repositioned sooner than this, but when she did bring R3 to his room, he didn't want to lay down but she said she should have repositioned him a little bit in his chair if he wanted to stay in the chair. NA-A stated it was important to reposition R3 so he didn't get any sores on his bottom, and he already had one on his side. During an interview on 2/27/26 at 10:37 a.m., the acting director of nursing (DON) stated her expectation was for skin and wounds to be checked at a minimum of weekly with documentation about how a wound looked, its characteristics, dressing appearance, odor or signs of infection. For R3, hospice did wound care on their visits and documented in their own charting system. The DON explained R3 had wound rounds with a contracted wound nurse practitioner along with a facility nurse (continued on next page)

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	245258	A. Building B. Wing	02/27/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manager. The wound nurse documented the wound measurements. The DON stated the risk of not doing so would be something didn't get noticed or treated in time and could get worse. At 12:46 p.m., the DON stated her expectation would be for R3 to be repositioned every two hours. During an interview on 2/27/26 at 11:18 a.m., primary care provider (PCP)-C stated he saw R3 on 12/1/25, and R3 had complained of pain in his toes on the right. The PCP stated he was concerned for infection in the toes and started doxycycline. The PCP would expect skin to be looked at every week, and stated the facility had a wound nurse who came to see the patients and she was very good, he was more comfortable with this. A policy, Skin Integrity dated 5/21/25, identified its purpose was to provide guidance to nursing staff on identifying, evaluating, monitoring, and preventing resident skin integrity issues. The care center will assess each resident's risk for skin integrity issues at move in, quarterly, with any significant change in condition, and with a new or potential pressure ulcer and will identify interventions to help prevent skin integrity issues.A licensed nurse will:a. Assess the area and identify the cause, if possible.b. Remove any source of pressure or trauma to the area.c. Clean the area and provide treatment per care center House Standing Orders.d. Determine if the skin integrity issue is reportable to the State Agency (SA). If yes,notify the Administrator and Director of Nursing and proceed with the SA reportingprocess. (CCEP.MP.SNF.005 Maltreatment Investigation & Reporting)e. Complete a Skin Incident report in the resident EHR.f. Notify resident and/or responsible party.g. Notify Provider and request treatment orders, if applicable.h. Notify the Nurse Manager, Wound Nurse, or designee.i. Initiate a new tissue tolerance for any newly opened area or redness.j. Initiate appropriate preventive measures based on the immediate root cause.C. Images of wound(s) will be taken utilizing approved equipment for medicaldocumentation, treatment planning, and monitoring progress.EvaluationA. Nurse Manager, Wound Nurse, or designee will assess and complete a root causeanalysis.B. Interdisciplinary Team (IDT) will review the skin incident report and evaluation of rootcause for further recommendations.C. The provider will review, to diagnosis, if root cause was not related to an injury (i.e., skintear, bruise), make recommendations, and/or initiate order(s). MonitoringA. A licensed nurse will complete the skin check weekly and document it in the EHR.B. Nurse Manager, Wound Nurse, or designee will assess all applicable wounds weeklyincluding pressure ulcers, venous ulcers, arterial ulcers, diabetic ulcers, MASD, and otherwounds of concern.a. Documentation will be completed in the resident electronic health record and willinclude describing the following characteristics:i. Locationii. Stage if pressure ulceriii. Measurements, including depth, undermining or tunneling/sinus tract.iv. Exudatev. Painvi. Wound bedvii. Wound edges and surrounding tissueviii. Signs and symptoms of infectionix. Progress towards healingx. Current interventions, including treatment, and any changes made to plan ofcare.b. The provider will be notified of any significant changes and/or a delay in healing.

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	02/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the continuous positive airway pressure machine (CPAP) was properly cleaned and maintained for 1 of 1 resident (R15) reviewed for respiratory care.Findings include:R15's annual Minimum Data Set (MDS) dated [DATE], indicated R15 was cognitively intact. Section O: Special Treatments, Procedures, and Programs was not coded for CPAP.R15's face sheet dated 2/27/26, included diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, congestive heart failure, and obstructive sleep apnea.R15's care plan revised 11/24/25, included CPAP settings but did not address standard cleaning and maintenance of CPAP for infection prevention.R15's provider orders dated 2/27/26, included:CPAP: staff to set up at HS and when in bed for naps. every shift Startup CPAP as machine is preprogrammed and will adjust to inhalation pressure needsNo evidence of orders for cleaning and maintenance of R15's CPAP machine.R15's treatment administration record (TAR) instructed staff to set-up the CPAP nightly and as needed for naps, but there were no instructions for cleaning and maintaining the CPAP. TARs dated 12/025, 1/2026, and 2/2026, had no instructions for cleaning and maintenance of R15's CPAP machine.During an observation on 2/23/26 at 12:33 p.m., R15's CPAP machine had visible water in the chamber.During an observation on 2/24/26 at 11:17 a.m., R15's CPAP machine had visible water in the chamber.During an observation on 2/25/26 at 1:24 p.m., R15's CPAP machine had visible water in the chamber.During an observation on 2/26/26 at 9:53 a.m., R15's CPAP machine had a dry water chamber.During an interview on 2/26/26 at 2:30 p.m., nursing assistant (NA)-B and NA-C stated the nurses started the CPAP, monitored, and cleaned it.During an interview on 2/26/26 at 2:44 p.m., registered nurse (RN)-A stated, nurses were responsible for placing the CPAP on the resident, monitoring it, and washing it per guidelines: daily empty and clean the humidifier and weekly clean the head gear, tubing, mask, and chin strap. RN-A stated CPAP orders, including cleaning, were on the TAR or MAR. They stated CPAP orders are expected on admission. They confirmed the importance of monitored use and cleaning for infection prevention.During an interview on 2/26/26 at 2:57 p.m., acting director of nursing (DON) stated residents with CPAPs should have had orders in place for CPAP application, water chamber filling, and for cleaning the CPAP machine and tubing/mask. They stated they would be concerned if a resident didn't have CPAP orders because the orders on the TAR were what let nursing know they needed to perform these tasks.During an observation on 2/27/26 at 11:30 a.m., R15's CPAP machine again had visible water in the chamber.The facility provided undated document Cleaning Your CPAP/Bi-level Equipment instructed daily wiping of mask, daily washing and air drying of humidifier, and weekly washing of the mask and head gear.A CPAP policy was requested but not received.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to offer influenza and pneumococcal vaccinations and or provide education according to Centers for Disease Control (CDC) guidelines for 3 of 5 residents (R12, R13, R8) reviewed for vaccinations.Findings include:R12's significant change Minimum Data Set (MDS) dated [DATE], identified R12 had diagnoses which included malignant neoplasm of right renal pelvis, hypothyroidism, dementia, and hypertension. A review of R12's immunization record identified they received the influenza vaccine on 11/4/25, education given was documented as no.R13's comprehensive MDS dated [DATE], identified R13 had diagnoses which included atrial fibrillation (fast, irregular heart rate), gastroesophageal reflux disease (GERD), benign prostatic hyperplasia (BPH [noncancerous enlargement of the prostate gland]), hyperlipidemia, arthritis, and depression.A review of R13's Vaccination Consent form dated 9/17/25, identified they wanted to receive the influenza vaccine during the influenza season. There was no evidence R13 was offered the vaccine during the immunization season.R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, and post-traumatic stress disorder (PTSD).A review of R8's immunization record identified they received the influenza vaccine on 11/4/25, education given was documented as no.During an interview on 2/26/26 at 12:18 p.m., the acting director of nursing acting (DON) stated when residents were admitted they received the Vaccine Information Statement (VIS) in their admission packet. The acting DON stated during the flu and cold season they have a vaccine clinic and re-do consents and VIS.During an interview on 2/26/26 at 3:36 p.m., the nurse consultant (NC)-B stated when flu season comes around new consents were obtained and new education was given along with a VIS.Resident Immunizations dated 1/21/25, identified the facility would offer vaccinations based on the Centers for Disease Control recommendations and physician orders. The policy further identified Vaccine Information Statements would be provided to the resident and/or representative prior to administration of the vaccination. Education would be provided and any questions answered prior to administration of the vaccine and documented in the electronic medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were educated on COVID-19 vaccinations when administered to 1 of 5 residents (R8).Findings include:R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R8 had diagnoses which included vascular dementia, depression, bipolar disorder, chronic pain, and post-traumatic stress disorder (PTSD).A review of R8's immunization record identified they received the Covid-19 vaccination on 11/4/25, education given was documented as no.During an interview on 2/26/26 at 12:18 p.m., the acting director of nursing acting (DON) stated when residents were admitted they received the Vaccine Information Statement (VIS) in their admission packet.During an interview on 2/26/26 at 3:36 p.m., the nurse consultant (NC)-B stated when vaccines were given new consents were obtained and new education was given along with a VIS.Resident Immunizations dated 1/21/25, identified the facility would offer vaccinations based on the Centers for Disease Control recommendations and physician orders. The policy further identified Vaccine Information Statements would be provided to the resident and/or representative prior to administration of the vaccination. Education would be provided and any questions answered prior to administration of the vaccine and documented in the electronic medical record.