Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

RE: CCN:245265
Cycle Start Date: June 9, 2026

Dear Administrator:

On June 9, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 9, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 9, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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June 16, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

Re: State Nursing Home Licensing Orders
Event ID: 2319B5-H1

Dear Administrator:

The above facility survey was completed on June 9, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 56520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 6/8/26 to 6/9/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		06/16/2026
F0000	INITIAL COMMENTS On 6/8/26 to 6/9/26, a federal recertification survey was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was not in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/26/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F0677	Immediate education was provided to the direct care staff on 06/9/2026 reviewing the importance of oral cares and those that require assistance with oral cares and how to find that information by the Resident Care Coordinator §483.24 (F 677). Care plans were reviewed to ensure all residents that are	08/01/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

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F0677 SS = D	Continued from page 1 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with routine grooming cares which included oral cares for 1 of 2 residents (R34) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene. Findings Include: R34's quarterly Minimum Data Set (MD) dated 4/28/26, identified R34 had severe cognitive impairment with diagnoses which included: Alzheimer's disease, anxiety and depression. R34's MDS identified R34 was dependent on staff for eating, oral hygiene, personal hygiene, and dressing. R34's care plan revised 5/13/26, identified R34 had self-care performance deficit related to Alzheimer's disease and dementia along with Impaired balance and weakness. R34 required total assistance of one with oral care and had own teeth in good condition. During telephone interview on 6/8/26 at 2:30 p.m., family member (FM)-A indicated they did not think staff routinely brushed R34's teeth. FM-A stated I think they do floss occasionally, but do not brush R34's teeth often enough. During observation on 6/9/26 at 7:06 a.m., nursing assistant (NA)-A was in R34's room attaching a sling for the stand- up lift to R34 while R34 sat on the edge of bed with assistance. At 7:07 a.m., NA-B entered room and assisted NA-A with the stand-up lift for R34, then they assisted R34 to the bathroom. NA-B left the room, then NA-A assisted R34 with washing and drying upper half of body, then applied R34's shirt and deodorant. At 7:16 a.m. NA-B came into R34's room and completed perineal cares, applied new brief and pants. NA-B assisted NA-A to transfer R34 to her wheelchair. NA-B left the room, then NA-A combed R34's hair, and applied perfume. NA-A made R34's bed, bagged up soiled clothing, linen, and garbage. NA-A wheeled R34 out to the common area near the TV. NA-A then sanitized hands. NA-A returned to room and disposed of soiled clothing, linens and garbage in soiled utility room. NA-A did not offer or complete oral cares for R34. At 8:12 a.m. R34 was assisted to the dining room, where staff fed her breakfast. During interview on 6/9/26 at 8:56 a.m., NA-A verified he did not offer to complete R34's oral cares or to brush R34's teeth. NA-A indicated he usually worked pm shift until a few weeks ago and was not used to morning cares. NA-B stated his usual practice was to complete oral cares in the evening. NA-A stated it was important to complete	F0677	Continued from page 1 in need of assistance were included on the CNA care plan by the Director of Nursing on 06/10/2026. St. Francis Home will implement mandatory staff training by the Director of Nursing 06/17/2026 for all nursing personnel regarding proper oral care protocols, including assistance with daily oral hygiene. The education will include and ensure staff understand the importance of following established care plans for all residents regarding oral hygiene, denture care and documentation. The oral hygiene policy has been reviewed by all staff and signed off for understanding. A complete review of all residents' care plans was completed to identify all other residents that may be affected by the deficient practice. To ensure compliance, St. Francis Home leadership will initiate random, weekly audits of oral care provision, effective 06/17/2026, for 60 days. The goal is to achieve 100% compliance with oral care documentation and provision, with immediate corrective action taken for any identified gaps. Audits will continue as needed beyond the initial 60-day period to ensure ongoing compliance and reported out to the QAPI committee.	08/01/2026

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F0677 SS = D	Continued from page 2 oral cares, so residents did not get cavities. NA-A stated it was difficult to be observed completing cares and most residents had dentures, so he was used to rinsing and applying dentures for residents in morning. During interview on 6/9/26 at 11:04 a.m., registered nurse (RN)-A stated expectation was for oral cares and brushing of teeth to be done with morning and evening cares. RN-A indicated oral cares were important, so residents did not develop infections, and for good oral hygiene. Director of Nursing (DON) was not available for an interview. The facility policy titled Grooming For Residents, undated, identified All residents would receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing manifested in part by being fully groomed. Residents who had their own teeth should have their teeth brushed every morning, every evening and as needed (PRN).	F0677		08/01/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	Immediate education was provided to the direct care staff on 06/9/2026 reviewing the importance of proper hand hygiene, standard and transmission based precautions and the PPE needed for those residents that require EBP during ADLs of high contact care and how to find that information on the CNA care plans in accordance with regulation §483.80 (F 880). This immediate education was provided by the Resident Care Coordinator. Care plans were reviewed to ensure all residents that are in need of EBP were included on the CNA care plan by the Director of Nursing on 06/10/2026. St. Francis Home will implement mandatory staff education by 06/17/2026 for all direct care personnel. This education will cover Standard and Transmission-based precautions including EBP (including resident identification and the clinical rationale for mitigating multidrug-resistant pathogens per CDC guidance), the "5 moments of hand hygiene," and proper hand hygiene and glove-changing protocols during resident care. Standard and Transmission-based precautions policy has been reviewed by all staff and signed off for understanding. A complete review of all residents' care plans to identify all other residents that may be affected by the deficient practice and CNA care plans were updated to reflect staffs' need for EBP compliance.. To ensure compliance, St. Francis Home leadership will initiate daily, random audits for 60 days starting 06/17/2026. These audits will monitor EBP usage, proper glove-changing procedures, and correct hand hygiene practices, with the goal of achieving 100%	08/01/2026

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ST FRANCIS HOME	2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 56520

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F0880 SS = D	Continued from page 3 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were completing hand hygiene and using proper personal protective equipment (PPE) according to the Centers for Disease Control (CDC) guidelines for enhanced barrier precautions (EBP) while performing activities of daily living (ADLs) for 1 of 1 residents (R2) observed for EBP.	F0880	Continued from page 3 compliance and immediate corrective action for any identified gaps. Audits will continue as needed beyond the initial 60-day period to ensure ongoing compliance and reported out to the QAPI committee.	08/01/2026

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F0880 SS = D	Continued from page 4 Findings Include: R2’s quarterly Minimum Data Set (MD) dated 6/4/26, identified R2 had paraplegia (loss of control of lower part of the body) and multiple sclerosis (an auto immune disease that affects the central nervous system). R2’s MDS further identified R2 had an indwelling catheter and colostomy. R2’s MDS revealed R2 was dependent on staff for personal hygiene, dressing, and transfers. R2’s care plan revised 6/5/26, identified R2 had a history of infections and was on EBP per CDC infection prevention guidelines due to R2’s indwelling catheter. R2’s room door displayed a sign informing staff that R2 was on EBP. R2’s door also provided a hanging cabinet that contained yellow gowns and gloves. Review of the CDC guidance dated 4/2/26, Implementation of PPE use in Nursing Homes to Prevent Spread of Multidrug-resistant organisms (MDRO), EBP are an infection control intervention designated to reduce transmission of resistant organisms that employes targeted gown and glove use during high contact resident care activities. During an interview and observation on 6/9/26 from 9:06 a.m. to 9:34 a.m., NA-A stated staff were going to get R2 up and dressed to go to breakfast. NA-A entered R2s room grabbed a pair of gloves from the hanging cabinet on R2s door and applied them. NA-A grabbed washcloths and towels out of R2s closet. NA-A grabbed the wash basins with supplies to provide personal hygiene for R2. NA-A removed R2's gown, checked R2's colostomy to ensure it was intact. NA-A removed gloves and applied a new pair of gloves. NA-A covered R2 up with a sheet and grabbed a pair of grey sweatpants and gold shirt out of R2's closet. NA-A filled R2's wash basin up and brought it out to the bedside table. NA-A removed R2's pressure relieving boots and two pillows under each side of R2. NA-A placed the washcloth into the basin and wrung it out. NA-A handed R2 the washcloth to wash R2's face and hands. NA-A took wash cloth from R2 placed put it in the basin and handed R2 a towel to dry face and hands. NA-A grabbed the washcloth wrung it out and washed R2's armpits. NA-A put the washcloth in the bag and the floor and dried R2's armpits. NA-A applied deodorant to R2's armpits and the applied R2's shirt. NA-A took another washcloth and placed it in the wash basin. NA-A wrung out the washcloth and washed R2's groin area. NA-A put	F0880		08/01/2026

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ST FRANCIS HOME	2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 56520

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F0880 SS = D	Continued from page 5 the washcloth back into the wash basin and dried R2's groin area with a towel. NA-A removed gloves and applied new gloves. NA-A went to the right side of the bed and pulled the lift sheet under R2 to prepare R2 to roll to R2's side. NA-B entered the room to assist NA-A to roll R2 to R2's side. NA-B applied one glove and assisted NA-A to roll R2. NA-A wrung out the washcloth and washed R2's coccyx area. NA-B applied second glove. NA-A put the washcloth into the bag on the floor and dried R2's bottom with a towel. NA-A put the towel into the bag on the floor. NA-A applied barrier cream to R2's bottom. NA-A removed gloves and applied new gloves. NA-B removed gloves. NA-A grabbed R2s sweatpants and put them on R2s legs. NA-A and NA-B rolled R2 from side to side to get R2s pants up and place sling under R2. NA-A went to the bathroom to grab a graduate. NA-A emptied R2's catheter, dumped the urine into the toilet, and rinsed the graduate out. NA-A removed gloves and applied new gloves. NA-B removed one glove, pulled paper out of pocket, wrote urine amount on paper, and placed paper back into pocket. NA-B removed gloves. NA-A tied up bag and the floor and left the room to get the lift. NA-A and NA-B hooked sling up to lift and transported R2 to electric wheelchair. NA-A removed gloves, sanitized hands and left the room with the lift. NA-B sanitized hands, grabbed the bag on the floor and left the room. NA-A returned to R2's room and assisted R2 with combing R2's hair. NA-A made R2s bed and placed a new trashcan liner in bin. R2 left room in electric scooter to go to breakfast. NA-A and NA-B did not wear gowns or sanitize their hand between glove changes. During an interview on 6/9/26 at 9:30 a.m., nursing assistant (NA)-B indicated NA-B was aware R2 was on EBP and NA-B did not wear proper PPE while providing personal cares for R2. NA-B further indicated NA-B did not sanitize hands during glove changes. During an interview on 6/9/26 at 9:36 a.m., NA-A indicated NA-A should have been wearing a gown when NA-A provided personal cares for R2. NA-A stated NA-A was aware R2 was on EBP and staff were supposed to use PPE when providing personal cares. NA-A further stated NA-A did not sanitize hands between glove changes. NA-A indicated NA-A thought about putting a gown on but did not want to stop cares for R2. During an interview on 6/9/26 at 10:33 a.m. registered nurse (RN)-B indicated R2 was on EBP and staff were expected to be putting on gowns,	F0880		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 56520

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F0880 SS = D	Continued from page 6 gloves and completing hand hygiene while providing R2's personal cares. During an interview on 6/09/2026 at 10:42 a.m., RN-A indicated RN-A assisted with infection control and had talked to staff about following EBP. RN-A further indicated EBP was discussed at meetings and staff received training on how to follow EBP. During an interview on 6/9/2026 at 10:47 a.m., administrator and vice president (VP) of patient services indicated the importance of EBP was to protect the residents and staff. Administrator and VP of patient services stated they would both expect staff to be compliant and follow EBP when providing personal cares to residents who are on EBP. Facility policy titled Isolation Precautions dated 11/22, identified healthcare personnel will utilize enhanced barrier precautions with all patient care activities to minimize exposure to potential pathogens as recommended by The Centers for Disease Control and Prevention (CDC). EBP was to be used with all residents have wounds and/or indwelling medical devices (urinary catheter).	F0880		08/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/26 to 6/9/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to	20000		06/26/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

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20000	Continued from page 1 Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		06/26/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were completing hand hygiene and using proper personal protective equipment (PPE) according to the Centers for Disease Control (CDC) guidelines for enhanced	21375	CORRECTED	08/01/2026

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21375	Continued from page 2 barrier precautions (EBP) while performing activities of daily living (ADLs) for 1 of 1 residents (R2) observed for EBP. Findings Include: R2's quarterly Minimum Data Set (MD) dated 6/4/26, identified R2 had paraplegia (loss of control of lower part of the body) and multiple sclerosis (an auto immune disease that affects the central nervous system). R2's MDS further identified R2 had an indwelling catheter and colostomy. R2's MDS revealed R2 was dependent on staff for personal hygiene, dressing, and transfers. R2's care plan revised 6/5/26, identified R2 had a history of infections and was on EBP per CDC infection prevention guidelines due to R2's indwelling catheter. R2's room door displayed a sign informing staff that R2 was on EBP. R2's door also provided a hanging cabinet that contained yellow gowns and gloves. Review of the CDC guidance dated 4/2/26, Implementation of PPE use in Nursing Homes to Prevent Spread of Multidrug-resistant organisms (MDRO), EBP are an infection control intervention designated to reduce transmission of resistant organisms that employes targeted gown and glove use during high contact resident care activities. During an interview and observation on 6/9/26 from 9:06 a.m. to 9:34 a.m., NA-A stated staff were going to get R2 up and dressed to go to breakfast. NA-A entered R2s room grabbed a pair of gloves from the hanging cabinet on R2s door and applied them. NA-A grabbed washcloths and towels out of R2s closet. NA-A grabbed the wash basins with supplies to provide personal hygiene for R2. NA-A removed R2's gown, checked R2's colostomy to ensure it was intact. NA-A removed gloves and applied a new pair of gloves. NA-A covered R2 up with a sheet and grabbed a pair of grey sweatpants and gold shirt out of R2's closet. NA-A filled R2's wash basin up and brought it out to the bedside table. NA-A removed R2's pressure relieving boots and two pillows under each side of R2. NA-A placed the washcloth into the basin and wrung it out. NA-A handed R2 the washcloth to wash R2's face and hands. NA-A took wash cloth from R2 placed put it in the basin and handed R2 a towel to dry face and hands. NA-A grabbed the washcloth wrung it out and washed R2's armpits. NA-A put the washcloth in the bag and the floor and dried R2's armpits. NA-A applied deodorant to R2's armpits and the	21375		08/01/2026

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21375	Continued from page 3 applied R2's shirt. NA-A took another washcloth and placed it in the wash basin. NA-A wrung out the washcloth and washed R2's groin area. NA-A put the washcloth back into the wash basin and dried R2's groin area with a towel. NA-A removed gloves and applied new gloves. NA-A went to the right side of the bed and pulled the lift sheet under R2 to prepare R2 to roll to R2's side. NA-B entered the room to assist NA-A to roll R2 to R2's side. NA-B applied one glove and assisted NA-A to roll R2. NA-A wrung out the washcloth and washed R2's coccyx area. NA-B applied second glove. NA-A put the washcloth into the bag on the floor and dried R2's bottom with a towel. NA-A put the towel into the bag on the floor. NA-A applied barrier cream to R2's bottom. NA-A removed gloves and applied new gloves. NA-B removed gloves. NA-A grabbed R2s sweatpants and put them on R2s legs. NA-A and NA-B rolled R2 from side to side to get R2s pants up and place sling under R2. NA-A went to the bathroom to grab a graduate. NA-A emptied R2's catheter, dumped the urine into the toilet, and rinsed the graduate out. NA-A removed gloves and applied new gloves. NA-B removed one glove, pulled paper out of pocket, wrote urine amount on paper, and placed paper back into pocket. NA-B removed gloves. NA-A tied up bag and the floor and left the room to get the lift. NA-A and NA-B hooked sling up to lift and transported R2 to electric wheelchair. NA-A removed gloves, sanitized hands and left the room with the lift. NA-B sanitized hands, grabbed the bag on the floor and left the room. NA-A returned to R2's room and assisted R2 with combing R2's hair. NA-A made R2s bed and placed a new trashcan liner in bin. R2 left room in electric scooter to go to breakfast. NA-A and NA-B did not wear gowns or sanitize their hand between glove changes. During an interview on 6/9/26 at 9:30 a.m., nursing assistant (NA)-B indicated NA-B was aware R2 was on EBP and NA-B did not wear proper PPE while providing personal cares for R2. NA-B further indicated NA-B did not sanitize hands during glove changes. During an interview on 6/9/26 at 9:36 a.m., NA-A indicated NA-A should have been wearing a gown when NA-A provided personal cares for R2. NA-A stated NA-A was aware R2 was on EBP and staff were supposed to use PPE when providing personal cares. NA-A further stated NA-A did not sanitize hands between glove changes. NA-A indicated NA-A thought about putting a gown on but did not want to stop cares for R2.	21375		08/01/2026

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21375	Continued from page 4 During an interview on 6/9/26 at 10:33 a.m. registered nurse (RN)-B indicated R2 was on EBP and staff were expected to be putting on gowns, gloves and completing hand hygiene while providing R2's personal cares. During an interview on 6/09/2026 at 10:42 a.m., RN-A indicated RN-A assisted with infection control and had talked to staff about following EBP. RN-A further indicated EBP was discussed at meetings and staff received training on how to follow EBP. During an interview on 6/9/2026 at 10:47 a.m., administrator and vice president (VP) of patient services indicated the importance of EBP was to protect the residents and staff. Administrator and VP of patient services stated they would both expect staff to be compliant and follow EBP when providing personal cares to residents who are on EBP. Facility policy titled Isolation Precautions dated 11/22, identified healthcare personnel will utilize enhanced barrier precautions with all patient care activities to minimize exposure to potential pathogens as recommended by The Centers for Disease Control and Prevention (CDC). EBP was to be used with all residents have wounds and/or indwelling medical devices (urinary catheter). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to hand hygiene and use of PPE for EBP. The DON or designee could educate staff on the policies and the quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		08/01/2026

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	245265	A. BUILDING **02 - MAIN BUILD...** B. WING	**06/09/2026**

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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/09/2026. At the time of this survey, St. Francis Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/26/2026

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 reverse for further 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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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This facility was surveyed as one building. St Francis Home is part of the St Francis Healthcare Campus. It was built in 2005, is a 1-story building, without a basement and was determined to be Type V (111) construction. It is separated from St Francis Healthcare Center with 3- hour fire barriers and is divided into 4 smoke zones with 1-hour fire barriers. The entire building is completely protected by an automatic fire sprinkler system equipped with quick response sprinkler heads. The facility has a manual fire alarm system with smoke detectors throughout the corridor system, in areas open to the corridors, and common areas that is monitored. The facility has a capacity of 110 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/26/2026

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K0345 SS = F Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on review of documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm Signaling Code, sections 14,4.5.3, and 14.4.5.3.2. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 06/09/2026 at 10:34 AM, it was revealed by review of available documentation that the facility had not had smoke detector sensitivity tested within the last 2 years. The last test took place on 05/31/2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0345	Summit Fire Protection has this function part of their annual inspection and this was not completed when they were here in April. Summit Fire Protection was contacted to complete this testing and it was completed on June 16. Facilities manager will check the annual report upon completion by Summit to verify this was completed. Facilities Manager will be responsible for monitoring and compliance.	06/16/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power	K0918	The emergency generator testing was tested and completed on June 18 by Interstate Power Systems. Fuel testing was completed on June 18 by Cenex. A PM work order has been created annually in April to generate a notice for the Facilities Manager to contact the two vendors for the annual testing. Facilities Manager will be responsible for monitoring and compliance.	06/18/2026

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K0918 SS = F Bldg. 02	Continued from page 3 sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.1, and 8.3.8. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 06/09/2026 at 10:52 AM, it was revealed by review of available documentation that the annual service for the emergency generator, including diesel fuel testing, had not occurred since 04/30/2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		06/18/2026
K0321 SS = D Bldg. 02	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K0321	There is currently a work order 12690197 to fix this particular problem, also there is a Door PM that covers this annual inspection A work order was placed to fix the door to close properly and the door has been fixed as of June 23. The facilities manager is 80 door certified and performs the annual door inspection to ensure certain doors with door closures close and latch properly. Doors are set up for PM (preventative maintenance work order) on an annual basis. Storage doors will be audited once a week for one month and then once a month for 3 months until 100% compliance is met. This information will be reported to the QAPI committee. Facilities Manager will be responsible for monitoring and compliance.	06/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/09/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS HOME	**2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 56520**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321 SS = D Bldg. 02	Continued from page 4 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.2.1.3. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 06/09/2026 at 11:53 AM, it was revealed by observation that the door for Storage Room 800 did not latch when closed using the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0321		06/23/2026