DEPARTMENT OF HE	ALTH AND HUN	IAN SERVICES			CENTERS FOR M	EDICARE & MEDICA	ID SERVICES
	MI	EDICARE/MEDI	CAID CERTIFIC	CATION A	ND TRANSMITTAL	ID:	4WN4
	PAl	RT I - TO BE CO	MPLETED BY T	THE STAT	E SURVEY AGENCY	Facil	ity ID: 00818
. MEDICARE/MEDICAID PR (L1) 245265		(L3) ST FRA	D ADDRESS OF FACIL	LITY		4. TYPE OF ACTION: 1. Initial	7(L8) 2. Recertification
2.STATE VENDOR OR MEDIC. (L2) 003543200	AID NO.	. ,	FRANCIS DRIVE ENRIDGE, MN		(L6) 56520	3. Termination 4. CHOW 5. Validation 6. Complaint	
6. EFFECTIVE DATE CHANG (L9)	E OF OWNERSHIP	7. PROVIDE	R/SUPPLIER CATEGO	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Comp	9. Other laint
	TJC		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DA	ATE: (L35)
2 AOA 3 1LTC PERIOD OF CERTIFIC	Other	10 THE FACII	ITY IS CERTIFIED AS	ζ.			
From (a):			npliance With		And/Or Approved Waivers Of T	he Following Requirements:	
To (b):		Prog	ram Requirements pliance Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Service 7. Medical Director	
2.Total Facility Beds	80 (L18		Acceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Siz	re e
3.Total Certified Beds	80 (L17	X B. Not i	n Compliance with Prog ents and/or Applied Wa		5. Life Safety Code * Code:	9. Beds/Room (L12)	
4. LTC CERTIFIED BED BRE	AKDOWN				15. FACILITY MEETS		
18 SNF 18/1	9 SNF 19 S	ENF ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (I	.38) (L.	39) (L42)	(L43)				
6. STATE SURVEY AGENCY	REMARKS (IF APPLI	CABLE SHOW LTC CA	ANCELLATION DATE	():			
7. SURVEYOR SIGNATURE		Da	ite:		18. STATE SURVEY AGENCY	APPROVAL	Date:
Gail Anderson	<u>, Unit Supervi</u>	sor	08/01/2018	(L19)	Kamala Fiske, Enfor	cement Specialist	08/01/2018 _{(L20}
	PART II - TO	O BE COMPLET	ED BY HCFA RI	EGIONAL	OFFICE OR SINGLE ST	ATE AGENCY	,

DETERMINATION OF ELIGIBILI 1. Facility is Eligible to I		20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 21. Statement of Financial Solv 2. Ownership/Control Interest 3. Both of the Above : 	
2. Facility is not Eligibl	e (L21)		_	_
22. ORIGINAL DATE OF PARTICIPATION	23. LTC AGREEMENT BEGINNING DATE	24. LTC AGREEMENT ENDING DATE	26. TERMINATION ACTION: VOLUNTARY 00	(L30)
06/01/1984	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANC		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	A. Suspension of Admis B. Rescind Suspension D	(L44) ate:		00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERI	MEDIARY/CARRIER NO.	30. REMARKS	
	03	001		
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERM	MINATION OF APPROVAL DATE		
	(L32)	(L33)	DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245265

August 1, 2018

Mr. David Nelson, Administrator St Francis Home 2400 St Francis Drive Breckenridge, MN 56520

Dear Mr. Nelson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 24, 2018 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kamala Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 1, 2018

Mr. David Nelson, Administrator St Francis Home 2400 St Francis Drive Breckenridge, MN 56520

RE: Project Number S5265027

Dear Mr. Nelson:

On June 26, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 25, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2018, effective July 24, 2018 and therefore remedies outlined in our letter to you dated June 26, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICAL MEDICA	CARE/MEDICAID CERTIFICATION	ON AND TRANSMITTAL	ID: 4WN4
PART I	- TO BE COMPLETED BY THE S	STATE SURVEY AGENCY	Facility ID: 00818
MEDICARE/MEDICAID PROVIDER NO. (L1) 245265 2.STATE VENDOR OR MEDICAID NO. (L2) 003543200	3. NAME AND ADDRESS OF FACILITY (L3) ST FRANCIS HOME (L4) 2400 ST FRANCIS DRIVE (L5) BRECKENRIDGE, MN	(L6) 56520	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 06/08/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 N	CF/IID 15 ASC	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 80 (L18) 14. LTC CERTIFIED BED BREAKDOWN	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B * 15. FACILITY MEETS	he Following Requirements:
18 SNF 18/19 SNF 19 SNF 80 (L37) (L38) (L39)	ICF IID (L42) (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	E SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY	APPROVAL Date:
Denise Erickson, HFE NE II	07/25/2018 (L	Douglas Larson, Enf	orcement Specialist 07/30/2018
PART II - TO BE	COMPLETED BY HCFA REGIO	ONAL OFFICE OR SINGLE ST	TATE AGENCY
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 06/01/1984		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburser	(L30) O INVOLUNTARY 05-Fail to Meet Health/Safety

	(==-/			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
06/01/1984			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS		03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
		(L44)		00-Active
(L27)	B. Rescind Suspension Date:			

(L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 26, 2018

Mr. David Nelson, Administrator St Francis Home 2400 St Francis Drive Breckenridge, MN 56520

RE: Project Number S5265027

Dear Mr. Nelson:

On June 8, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 18, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 18, 2018 the following remedy will be imposed:

• Civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 8, 2018 (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). This mandatory denial of payments will be based on

St Francis Home June 26, 2018 Page 5

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 8, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St Francis Home June 26, 2018 Page 6

> St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

DOWNES LADSON

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 07/27/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245265	B. WING_		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted on 6/4/1 recertification surve	iance with CMS Appendix Z edness Requirements, was 8, through 6/8/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	00		
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 607 SS=C	on-site revisit of you validate that substate regulations has been your verification. Develop/Implement	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with the Abuse/Neglect Policies 1)-(3)	F 6	07		7/18/18
		ility must develop and procedures that:				
		ibit and prevent abuse, tation of residents and resident property,				
		blish policies and procedures uch allegations, and				
	paragraph §483.95	de training as required at , NT is not met as evidenced				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

07/06/2018

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.

TITLE

F 607 Continued From page 1 by: Based on interview and document review, the facility failed to develop an abuse prevention policy which included a policy and procedure to ensure timely notifications to the state agency (SA) of suspected and/or potential abuse and neglect reporting. This had the potential to affect all residents in the facility. Findings include: Review of the facility's policy titled: Vulnerable Adult Abuse and Neglect Reporting revised 1/18, revealed the facility was to notify the SA immediately, but no longer than 24 hours after the initial knowledge of the incident had occurred. The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
ST FRANCIS HOME SUMMARY STATEMENT OF DEFICIENCIES BRECKENRIDGE, MN 56520			245265	B. WING _		06/	08/2018
CALL DEFICE NOTE	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00.2010
CALL DREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	ST EDAN	ICIS HOME			2400 ST FRANCIS DRIVE		
F 607 Continued From page 1 by: Based on interview and document review, the facility failed to develop an abuse prevention policy which included a policy and procedure to ensure timely notifications to the state agency (SA) of suspected and/or potential abuse and neglect reporting. This had the potential to affect all residents in the facility. Review of the facility's policy titled: Vulnerable Adult Abuse and Neglect Reporting revised 1/18, revealed the facility was to notify the SA immediately, but no longer than 24 hours after the initial knowledge of the incident had occurred. The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	SIFKAN	NCIS HOIVIE			BRECKENRIDGE, MN 56520		
by: Based on interview and document review, the facility failed to develop an abuse prevention policy which included a policy and procedure to ensure timely notifications to the state agency (SA) of suspected and/or potential abuse and neglect reporting. This had the potential to affect all residents in the facility. Review of the facility's policy titled: Vulnerable Adult Abuse and Neglect Reporting revised 1/18, revealed the facility was to notify the SA immediately, but no longer than 24 hours after the initial knowledge of the incident had occurred. The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident votages. The Vulnerable Adult policy was revised June 2018 so that the facility-wide policy definition of immediate was revised to within 2 hours. Further clarification of the immediate reporting in the Long-Term Care addendum included the addition of abuse and neglect to bodily harm. The policy revision will be applied to all resident incidents. Verbal education on the definition of immediate will be conducted at daily Safety Huddles for 1 week. Copies of the policy with the revisions highlighted will be posted on each neighborhood and staff are required to sign off that they have read and understood the changes. Additional training will be conducted with all staff during the annual Skills Day training this month. PRN staff will receive	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures prior to the start of the investigation. education material via mail with a signature page that must be returned stating that they have read and understood the changes. Vulnerable Adult reporting will be monitored through the Daily Incident and Accident report monitoring, as well as the Quality Assurance/Performance Improvement audits which are conducted by Social Services. Monitoring will continue until 4 consecutive months of compliance have been attained. Responsible: DON and Social Worker	F 607	by: Based on interview facility failed to dew policy which include ensure timely notifit (SA) of suspected neglect reporting. This had the poten facility. Findings include: Review of the facility. Findings include: Review of the facility immediately, but no initial knowledge of the policy failed to violations involving mistreatment, inclusiource and misappare reported immediate that cause the allegin serious bodily injif the events that ca involve abuse and injury, to the adminother officials (incluated Agency and adult plaw provides for jurfacilities) in accordes established procedinvestigation. On 6/7/18, at 3:05	v and document review, the relop an abuse prevention ed a policy and procedure to cations to the state agency and/or potential abuse and tial to affect all residents in the ty's policy titled: Vulnerable eglect Reporting revised 1/18, was to notify the SA to longer than 24 hours after the fithe incident had occurred. include that all alleged abuse, neglect, exploitation or reding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result lury, or not later than 24 hours ause the allegation do not do not result in serious bodily distrator of the facility and to uding to the State Survey protective services where state insdiction in long-term care ance with state law through lures prior to the start of the	F 60	The Vulnerable Adult policy June 2018 so that the facility definition of immediate was within 2 hours. Further clari immediate reporting in the L Care addendum included the abuse and neglect to bodily. The policy revision will be appresident incidents. Verbal education on the definimmediate will be conducted Safety Huddles for 1 week. policy with the revisions high posted on each neighborhood are required to sign off that the read and understood the chandditional training will be conall staff during the annual Stating this month. PRN stateducation material via mail with signature page that must be stating that they have read a understood the changes. Vulnerable Adult reporting with monitored through the Daily Accident report monitoring, a Quality Assurance/Performal Improvement audits which a by Social Services. Monitor continue until 4 consecutive compliance have been attain	y-wide policy revised to fication of the ong-Term e addition of harm. oplied to all inition of d at daily Copies of the od and staff they have anges. Inducted with kills Day aff will receive with a e returned and incident and as well as the once are conducted ing will months of ned.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245265	B. WING_		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 607	confirmed the curre stated they were no requirement of repo events which cause DON stated they fe directed any allegat immediately but no requirements.	(DON), the LSW and DON ent facility policy and both of aware of the 2 hour porting allegations of abuse or ed serious bodily injury. The lt the facility policy which cions were to reported later than 24 hours met the	F 60			
SS=D	§483.12(c) In responeglect, exploitation must: §483.12(c)(1) Ensure involving abuse, nemistreatment, inclusource and misappare reported immediate that cause the allegistration bodily injury the events that cause and do not rethe administrator of officials (including the administrator).	onse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations glect, exploitation or ding injuries of unknown repriation of resident property, diately, but not later than 2 gation is made, if the events pation involve abuse or result in a contract that in a contract the facility and to other the State Survey Agency and wices where state law provides ing-term care facilities) in ate law through established	F 60) 9		7/18/18
	designated represe accordance with St	ort the results of all e administrator or his or her ntative and to other officials in ate law, including to the State hin 5 working days of the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE COMP	SURVEY LETED
		245265	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	incident, and if the appropriate correct This REQUIREMEI by: Based on interview facility failed to ens neglect were imme 24 hours if the ever do not involve abus bodily injury to the 3 thorough investigat reviewed for potent	alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the ure incidents of potential diately reported, no later than into that cause the allegations is and do not result in serious State Agency, and conduct a ion for 1 of 2 residents (R56) ial neglect when a fall	F 609	A Vulnerable Adult report will be ma all falls involving the use of a mecha lift to assure all incidents are proper reported. The revision will be applied to all res incidents involving falls while using to mechanical lifts.	anical fly sident	
	Findings include: R56's quarterly MD R56 was cognitively which included ane and hemiplegia (on identified R56 had impairment and rectwo staff for ADL's transfers. The MDS since the last quart R56's CAA dated 9 assistance from statransfers and indica R56 when she was were not familiar whad no recent falls. R56's incident detarevealed R56 had is stand lift and one fabed to the bathroor the NA turned the life.	/19/17, identified R56 required aff and a sit to stand lift for ated two staff should assist not feeling well or if the staff ith her. The CAA indicated R56		Verbal education on following the Vulnerable Adult procedures when ta fall or near miss with the use of the mechanical lifts will be conducted at Safety Huddles for 1 week. Copies policy with the revisions highlighted posted on each neighborhood and sare required to sign off that they have read and understood the changes. Additional training will be conducted all staff during the annual Skills Day training this month. PRN staff will reducation material via mail with a signature page that must be returned stating that they have read and understood the changes. The Vulnerable Adult policy updated reflect that VA's will be submitted to State agency and then an investigat will occur. Vulnerable Adult reporting will be monitored by Social Services and Nathrough the Daily Incident and Accidence of the point and review of nurse notes to	t daily of the will be staff ve I with veceive ed I to the tion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 565	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 609	lowered to the floor identified the whee report revealed the manager had immeservice and biomed. The report did not ident had been in the optime of the fall. The documentation of the equipment malfund. On 6/7/18, at 2:15 incident report date the DON. The DON during a transfer with confirmed R56's incanalysis and comporting R56's fall on 11/2/1 report did not ident had been opened on sit to stand lift, and would be a key confort cause of the siconfirmed she had to discuss any other have caused the lift bolt to break. The Ewhether all of the opreventative mainted the incident with the On 6/7/18, at 2:30 reported R56's fall	R56's incident report I to the lift had broken off. The facility's maintenance ediately removed the lift from I had taken the lift for service. I R56 was to be assisted to aff and a sit to stand lift. The ify whether the legs to the lift ened or closed position at the report lacked further ne possible causes for the	F6	ensure all incidents are appropriately. Quality Assurance/Performance audits which are conduservices and charge not reported at QAPI meetic continue until 4 consect compliance have been Responsible: DON and	ce Improvement sucted by Social urse will be ing. Monitoring will cutive months of attained.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245265	B. WING _		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636 SS=D	On 6/7/18, at 3:30 pabuse prohibition a with the DON and L confirmed the polic for cases of reporter abuse/neglect. Review of the facility Adult Abuse and Nervealed the facility immediately, but not initial knowledge of A facility policy titled (Nursing Home) revealed the need for a VA restate agency. Comprehensive As CFR(s): 483.20(b)(§483.20 Resident A The facility must coar a comprehensive, a reproducible assess functional capacity. §483.20(b) Compre §483.20(b)(1) Res A facility must make assessment of a regoals, life history ar resident assessment by CMS. The asset the following:	o.m. the facility's policy for and reporting was reviewed LSW-A, both of which y lacked the two hour reporting ed and/or suspected by's policy titled: Vulnerable eglect Reporting revised 1/18, was to notify the SA or longer than 24 hours after the the incident had occurred. It Appendix B-Long Term Care wised 1/18, revealed it was the omplete an initial investigation accident report to determine eport to be submitted to the sessments & Timing 1)(2)(i)(iii) Assessment and periodically accurate, standardized sment of each resident's each resident's needs, strengths, and preferences, using the int instrument (RAI) specified ssment must include at least a demographic information	F 6			7/24/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245265	B. WING			06/	08/2018
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 636	(iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical functi (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plan (xvii) Documentation regarding the addition the care areas to the Minimum Data (xviii) Documentation the care areas to the Minimum Data (xviii) Documentation assessment. The ainclude direct observing the resident, and licensed and nonlice members on all shirt systems of a retimeframes prescribed in \$43.20(b)(2) Whe timeframes specificate through (iii) of this sprescribed in \$413.20(b)(c) When the care areas the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the care areas the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the care areas the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the care areas the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the care areas the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of this sprescribed in \$413.20(b)(c) When the first of a retimeframe specificate through (iii) of t	ens. avior patterns. well-being. oning and structural problems. sis and health conditions. itional status. s. ents and procedures. nning. on of summary information ional assessment performed riggered by the completion of Set (MDS). on of participation in assessment process must rvation and communication is well as communication with ensed direct care staff	F	536			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	'	X3) DATE SURVEY COMPLETED
		245265	B. WING		06/08/2018
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 636	following a tempora or therapeutic leave (iii)Not less than or This REQUIREMED by: Based on interview facility failed to ens Assessments (CAA analysis of a reside history and prefere reviewed for nutrition of the findings include: R1's significant chat Minimum Data Set identified R1 had dementia, diabetes psychotic disorder identified R1 had mand required exten all activities of daily eating. Further, the pounds, a therapeut 5%, or more in the more in the last 6 m. R1's significant chat Assessment (CAA) Nutritional Status Cactual problem for explain the nature of had a significant chand to see chart not CAA revealed multimarked areas (from	ary absence for hospitalization e.) ince every 12 months. NT is not met as evidenced of and document review, the ure resident Care Area (A) included a comprehensive ent's needs, strengths, goals, inces for 1 of 4 residents (R1) on. ange in status assessment (MDS) dated 5/16/18, iagnoses which included: is mellitus, anxiety, depression, and glaucoma. R1's MDS incoderately impaired cognition sive assistance from staff for a living (ADLs) which included in MDS identified a weight of 98 of last month or loss of 10% or nonths. ange in status Care Area of dated 5/29/18, identified for CAA, the care area was an R1, however, the CAA did not of the problem, it indicated R1 in ange conference on 5/24/18, ote from the conference. The iple pre-populated check in data entered on the MDS),	F 636	R1 expired on 6-17-18. CAA's will be reviewed and updated weekly IDT meetings. RN's, Dietician and AM Dietary Supe will be educated on thorough complet of CAA's. Verbal education on appronutritional interventions relating to we loss will be conducted at daily Safety Huddles for 1 week. Written educati will be posted on each neighborhood staff are required to sign off that they read and understood the changes. Additional training will be conducted all staff during the annual Skills Day training this month. PRN staff will reeducation material via mail with a signature page that must be returned stating that they have read and understood the changes. Dietary manager and DON conduct weekly audits on 3 charts per week f weeks and then 1 chart weekly until next QAPI meeting to assure that CA are completed. A performance improvement will will be completed a reviewed at next QAPI meeting. Monitoring will continue until 4 consecutive months of compliance have a superior weekly and the completed and consecutive months of compliance have a superior will will be compliance in the consecutive months of compliance have a superior will will be compliance in the consecutive months of consecutive months	ervisor etion priate eight on I and have with ceive d for 4 the AA's
	ability to eat, cognit	actional problems that affect tive, mental status and us that could interfere with		been attained. Responsible DON and Director of	

OLITIC	TO I OIL MEDIONILE	A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING	;		06/	08/2018
	PROVIDER OR SUPPLIER			24	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 636	eating, communica and conditions that nutritional needs, mad factors. Each of the had a comment are additional informati problems, but each were blank. Under Findings, the instru Indicators & Suppo Conclusions. Docu Description of the Fontributing Factor Care Area" however was left blank. The analysis of the afor checkmarks, which status. The CAA fur considerations that status from resident.	tion problems, other diseases could affect appetite or nedications and environmental above pre-populated areas awhere staff could add on/analysis of the identified of the six comment areas the heading Analysis of ctions indicated, "Review rting Documentation & Draw ment the Following: Problem, Causes and is, Risk Factors Related to the er, the comment section for this CAA lacked a comprehensive ementioned pre-populated impacted R1's nutritional rther lacked any other could affect R1's nutritional it observation and resident we input for care planning	F	636	Nutrition Services		
	Trail for R1 dated 5 was Nutritional Stat questions with ansy "Cardiac Drugs", w second question was Comment", with an conference was he from the conference "Care Planning Dec answer "Proceed to Risk Assessment, of Review of R1's sign conference chart no	rovided Resident CAA Audit 5/25/18, indicated the CAA type tus. The Audit Trail had 3 CAA wers. The first question was ith an answer of "No". The as "Current Eating Pattern answer of "Significant Change Id on 5/24/18. See chart note e". The third question was cision Comment", with the care plan. CAA, Care Plan, etc, completed/updated." Inificant change care ote dated 5/25/18, indicated a pounds, which was down 14					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06/	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	SHOULD BE COMPLETI	
F 636 F 686 SS=D	pounds since Febru psychiatric stay and indicated R1's aver was poor. Staff wer powder with each g (nutritional supplem no further documentati for continued weight considerations or in prevent further weight of the considerations or in prevent further weight on 6/8/18, at 11:25 (DS)-A confirmed s Status CAA dated 5 usual practice was and answer the que chart note. DS-A status CAA. DS-A stated s CAA was a comprenutritional status. On 6/8/18, at 11:43 (DON) stated she w Status CAA to be a of her individual nut Treatment/Svcs to CFR(s): 483.25(b)(1) Press Based on the compresident, the facility (i) A resident receiv professional standal pressure ulcers and ulcers unless the in	lary, R1 had a recent inpatient if a regular diet. The note age meal food and fluid intake in the tocontinue to offer protein lass of milk, continue Juven in the lacked any in the lacked any in the lacked any in the lacked further interventions to attempt to ght loss. a.m. dietary supervisor the completed R1's Nutritional in the CAA in the lacked the chart note was the set of the chart note was the set of the lacked the chart note was the set of the lacked the chart note was the set of the lacked the chart note was the set of the lacked the chart note was the set of R1's Nutritional Status then sive analysis of R1's a.m. director of nursing would expect R1's Nutritional comprehensive assessment crition needs. Prevent/Heal Pressure Ulcer 1)(i)(ii) regrity sure ulcers. The note and fluid intake in the lacked any interventional interventionality interventional interventional interventional interventional i	F 68			7/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	
ST FRAN	ICIS HOME			2400 ST FRANCIS DRIVE		
OTTIVAL	TOIO TIOME			BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	Continued From page (ii) A resident with necessary treatment with professional supromote healing, pure ulcers from detailing the promote healing, pure ulcers from detailing the pressure from detailing the pressure relieving (R7) reviewed at risure in the profession of the professio	age 10 pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent eveloping. ENT is not met as evidenced ation, interview and document failed to consistently implement interventions for 1 of 1 resident sk for pressure ulcers. Inimum Data Set (MDS) dated R7 had severely impaired noses which included: se, dementia and anemia. The was totally dependent on staff daily living (ADLs), did not walk. It identified R7 was at risk for of pressure ulcers, and was on sitioning program. Se dated 3/9/18, identified R7 ired cognition, was totally for ADLs, remained at risk for ressure ulcers and was not on	F 6	DEFICIENCY)	dle board and and and must have always and ulcer always ch reflect for risk of with noted quarterly ue tolerance put in place feekly audits s who have in breakdown ations have skin integrity. ted on protectors and worn	
	dated 10/20/17, re development of pro- a functional limitati incontinence, cogn Alzheimer's diseas turning schedule. I intact with exception	vealed R7 had risk factors for essure ulcers of immobility with ion in range of motion, nitive loss with a diagnosis of se and required a regular R7's CAA listed her skin was on of a dry scab on her right by toe. The CAA directed to		Education on blue heel protect and following the care sheets quality resident care will be contained and Safety Huddles for 1 were ducation will be posted on expension of that they have read a understood the changes. Add	for providing onducted at ek. Written ach equired to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING			06/0	08/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CT EDAN	ICIS HOME			24	400 ST FRANCIS DRIVE		
SIFRAN	ICIS HOWE			В	RECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
protector boots at all times reposition every 2 to 3 hou		down R7 was to wear blue heel ill times, and turn and o 3 hours.	F 6	86	training will be conducted with all siduring the annual Skills Day trainin month. PRN staff will receive educematerial via mail with a signature process.	g this ation age	
	R7's care plan, revised 4/3/18, identified R7 was at risk for impaired skin integrity related to decreased mobility/unable to turn and reposition self. R7's care plan listed various interventions which included blue heel protector boots on at all times, and a photo was posted in her room with correct placement of feet in chair when up, and turn and reposition every 2 to 3 hours. On 6/6/18, at 7:46 a.m. R7 was observed lying on bed with nursing assistant (NA)-F and NA-G present in the room. R7 had blue heel boots on both feet, however, R7's boots were not secured to her feet and her heels did not rest in the holes of the boots. Both heels rested directly on the inside of the protectors. NA-F and NA-G transferred R7 into a Broda chair and her blue boots were present but not secured with Velcro straps and both heels did not rest in the holes of the boots. At 8:18 a.m. R7 remained seated in her Broda chair, with both heel protectors present, but both heels not resting in the holes of the protectors. R7's heels rested directly on inside of the blue protectors. At 8:34 a.m. R7 remained seated in the Broda chair, with both heels resting directly on the padding of the heel protectors. NA-F was seated next to R7 assisting her to eat her breakfast in the dining room. At 9:12 a.m. R7 remained seated in her Broda chair, with her heels continuing to rest directly on the inside of the protectors. NA-F and NA-G pushed her in the Broda chair to her room and assisted R7 to transfer to bed. NA-G moved the blue heel			that must be returned stating that the have read and understood the charman and blue protectors are in place and worn on a performance improvement plan wimplemented and reviewed at next meeting. Monitoring will continue to consecutive months of compliance		heel prrectly. vill be QA until 4	
					been attained. Responsible: DON		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245265	B. WING		·····	06/	08/2018
	PROVIDER OR SUPPLIER	-	,	240	REET ADDRESS, CITY, STATE, ZIP CODE 10 ST FRANCIS DRIVE ECKENRIDGE, MN 56520	, 33	
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICLENCY)) BE	(X5) COMPLETION DATE
F 686	correctly and place to reposition her of On 6/6/18 continuous conducted from 1:2 p.m. NA-F and NA room and assisted chair to bed leaving place on the foot be and NA-G proceed cares and position back onto her side on the mattress. Robserved on the foon pillows were plategs. At 1:35 p.m. I C entered R7's room. LPN-C R7's heels rested blue heel protector heels. R7's blue he Broda chair and no near R7's feet and walked past R7's room. R7's heels redirectly on the mattlaundry personnel exited. No other standard to the company of t	ed a pillow under her right side	F6	886			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06/	/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 686	every two hours an blue heel boots at a At 2:21 p.m. R7 rer with both heels rest the bed. LPN-C wadirectly on the matt. At 2:22 p.m. LPN-C blue heel protectors not aware if she wo After review of R7's was to wear the blushe indicated R7's right heel but did no present. She indicated the past, and she word left heel was so indented when LPN there were no open. On 6/6/18 at 2:32 p (RNCC)-A confirmed ulcer development decreased mobility She stated she word floated off the mattress because of ulcer development. On 6/8/18 at 12:00 (DON) confirmed fulcers due to her in move herself. She in the state of the mattress because of ulcers due to her in move herself. She in the state of the mattress due to her in move herself. She in the state of the mattress due to her in move herself. She in the state of the st	d indicated R7 was to wear the all times. mained in the same position, ting directly on the mattress of s notified of R7's heels resting ress at that time. C stated R7 only utilized the swhile in the chair, and was one the heel protectors at night. It is care plan, LPN-C stated R7 are heel protectors at all times. I left heel was softer than the ot have any open areas at atted R7's heels had been red in would expect the heel at all times. At 2:25 p.m. R7's red with LPN-C who confirmed the protection of the pr	F 68	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(3) DATE SURVEY COMPLETED		
		245265	B. WING		06/08/2018
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686		e ulcer prevention was	F 686		
	CFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The reason of accident §483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on observatoreview, the facility for safe use of a mech (R53, R56) reviewe sit to stand lifts. Findings include: R53's admission M identified R53 had sand had diagnosis of the demonstration orientation.	azards/Supervision/Devices 1)(2) ats.	F 689	Resident who slid from the stand-up lift now transfers with a pivot disc and 2 sta Facility has purchased slings of different sizes ranging from xsmall to XXL to ensure each resident will be using appropriate size for their weight. Staff who be educated on new upcoming sling siz relating to resident's weight when the slings arrive and prior to be putting into use. Bio med has completed and will continue to complete routine maintenance on lifts as directed according to manufacturer recommendations to assure that all lifts are in proper working order.	aff. t vill es e s
	wheelchair.	ility and locomotion with a are Area Assessment (CAA)		All residents currently using the stand-u lift for transfers will be assessed by IDT next meeting (7/3/18) ensuring they are appropriate to use the standup lift.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	dated 4/30/18, identicognitive impairme assistance from facindicated R53 had a R53's fall risk asseridentified R53 was included the following periods of altered programmed procession, mobility, bally health conditions. R53's care plan reversion, mobility impairmed required assistance transfer belt, pivot of R53's fall incident in R53 had been assistand mechanical list wheelchair to bed. R53 had let go of the through the sling and R53's incident reposite intervention had be to transfer with 2 as R53's fall incident in revealed R53's fall and had no further with two assist. On 6/6/18, at 7:32 as wheelchair in front kitchen area of the her breakfast and as sistematical in the streakfast and as sistematical i	tified R53 had severe nt and required physical cility staff for ADL's. The CAA significant malnutrition. ssment dated, 4/29/18, at high risk for falls due ng indicators; easily distracted, perception or awareness of essness, impaired cognition, ance, age, medications and rised 6/4/18, revealed R53 had nt, was at risk for falls and e with transfers using a	F 689	Biomed completed routine mai on all lifts 6-20-18. IDT will review appropriateness lift being used for all residents MDS assessment. Facility will purchasing new slings for the state that would be different sizes be resident weight. Bio med w lift routine maintenance as directly according to manufacturer secommendations. Education on proper mechanic conducted at daily Safety Hudoweek. Written education will be each neighborhood and staff at to sign off that they have read a understood the changes. Additraining will be conducted with during the annual Skills Day tramonth. PRN staff will receive material via mail with a signature that must be returned stating the have read and understood the Audits will be conducted week! That aides are using the appropriate for stand up lifts. A performing rovement plan will be implead reviewed at next QA meeting Monitoring will continue until 4 consecutive months of compliate been demonstrated. Responsible: DON	s of current with each be standup lifts ased on ill complete ected al lift will be dles for 1 e posted on re required and tional all staff aining this education are page nat they changes. y to assure priate sling nance emented ing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245265	B. WING		06/	08/2018	
		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	_D BE	(X5) COMPLETION DATE	
On 6/6/18, at 8:59 wheelchair while now wheeled R53 to he restorative nursing R53's room to assist a transfer belt across a pivot disk (assisting residents to pivot the floor in front placed her foot on R53 to stand, while her foot. R53 was a disk, turned and sacued by RNA-A. On 6/6/18, at 7:06 (LPN)-C stated R53 admission a few mhad fallen during a mechanical lift. LPI the handle bars of sling and onto her following R53's fall used the FBL until transfers. On 6/7/18, at 2:46 fall incident on 5/16 director of nursing officer/educator (Schad fallen while shousing a sit to stand let go of the handle that was the cause	a.m. R53 was seated in her ursing assistant (NA)-G r room. At that time facility assistant (RNA)-A entered st with transfer. NA-G donned as R53's torso, RNA-A placed are device used to assist ansfer with assist and ease) of R53's wheelchair. NA-G at the pivot disk and assisted a RNA-A cued R53 to turn with able to pivot with the use of the at on the edge of the bed when are a.m. licensed practical nurse are quired assistance with acility staff and a pivot disk. had fallen once since her onths ago. She stated R53 transfer with a sit to stand N-C stated R53 had let go of the lift and had slid through the buttocks. LPN-C stated from the sit to stand lift, staff R53 was able to assist with p.m. R53's medical record and ab/18, were reviewed with the (DON) and the facility safety O)-A. The DON confirmed R53 e was assisted to transfer lift. The DON stated R53 had as during the transfer and felt of R53's fall. The DON	F 689				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa On 6/6/18, at 8:59 wheelchair while now wheeled R53 to he restorative nursing R53's room to assis a transfer belt across a pivot disk (assisting residents to pivot to the floor in front placed her foot on R53 to stand, while her foot. R53 was a disk, turned and sacued by RNA-A. On 6/6/18, at 7:06 (LPN)-C stated R53 admission a few mhad fallen during a mechanical lift. LPI the handle bars of sling and onto her following R53's fall used the FBL until transfers. On 6/7/18, at 2:46 fall incident on 5/16 director of nursing officer/educator (Schad fallen while shousing a sit to stand let go of the handle that was the cause confirmed R53 had	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 6/6/18, at 8:59 a.m. R53 was seated in her wheelchair while nursing assistant (NA)-G wheeled R53 to her room. At that time facility restorative nursing assistant (RNA)-A entered R53's room to assist with transfer. NA-G donned a transfer belt across R53's torso, RNA-A placed a pivot disk (assistive device used to assist residents to pivot transfer with assist and ease) on the floor in front of R53's wheelchair. NA-G placed her foot on the pivot disk and assisted R53 to stand, while RNA-A cued R53 to turn with her foot. R53 was able to pivot with the use of the disk, turned and sat on the edge of the bed when cued by RNA-A. On 6/6/18, at 7:06 a.m. licensed practical nurse (LPN)-C stated R53 required assistance with transfers with two facility staff and a pivot disk. LPN-C stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen during a transfer with a sit to stand mechanical lift. LPN-C stated R53 had let go of the handle bars of the lift and had slid through the sling and onto her buttocks. LPN-C stated following R53's fall from the sit to stand lift, staff used the FBL until R53 was able to assist with	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 6/6/18, at 8:59 a.m. R53 was seated in her wheelchair while nursing assistant (NA)-G wheeled R53 to her room. At that time facility restorative nursing assistant (RNA)-A entered R53's room to assist with transfer. NA-G donned a transfer belt across R53's torso, RNA-A placed a pivot disk (assistive device used to assist residents to pivot transfer with assist and ease) on the floor in front of R53's wheelchair. NA-G placed her foot on the pivot disk and assisted R53 to stand, while RNA-A cued R53 to turn with her foot. R53 was able to pivot with the use of the disk, turned and sat on the edge of the bed when cued by RNA-A. On 6/6/18, at 7:06 a.m. licensed practical nurse (LPN)-C stated R53 required assistance with transfers with two facility staff and a pivot disk. LPN-C stated R53 had fallen once since her admission a few months ago. She stated R53 had let go of the handle bars of the lift and had slid through the sling and onto her buttocks. LPN-C stated R53 had let go of the handle bars of the lift and had slid through the sling and onto her buttocks. LPN-C stated following R53's fall from the sit to stand lift, staff used the FBL until R53 was able to assist with transfers. On 6/7/18, at 2:46 p.m. R53's medical record and fall incident on 5/16/18, were reviewed with the director of nursing (DON) and the facility safety officer/educator (SO)-A. The DON confirmed R53 had let go of the handles during the transfer and felt that was the cause of R53's fall. The DON confirmed R53 had been using a universal sling,	PROVIDER OR SUPPLIER 245265 2400 ST FRANCIS DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 6/6/18, at 8:59 a.m. R53 was seated in her wheelchair while nursing assistant (RNA)-G wheeled R53 to her room. At that time facility restorative hursing assistant (RNA)-A entered R53's room to assist with transfer. NA-G donned a transfer beth across R53's torso, RNA-A placed a pivot disk (assistive device used to assist residents to pivot transfer with assist and ease) on the floor in front of R53's wheelchair. NA-G placed her foot on the pivot disk and assisted R53 to stand, while RNA-A cued R53 to turn with her foot. R53 was able to pivot with the use of the disk, turned and sat on the edge of the bed when cued by RNA-A. On 6/6/18, at 7:06 a.m. licensed practical nurse (LPN)-C stated R53 required assistance with transfers with two facility staff and a pivot disk. LPN-C stated R53 nequired assistance with transfers with two facility staff and a pivot disk. LPN-C stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen during a transfer with a sit to stand lift, staff used the FBL unit R53 was able to assist with transfers. On 6/7/18, at 2:46 p.m. R53's medical record and fall incident on 6/16/18, were reviewed with the director of nursing (DON) and the facility safer using a sit to stand lift. The DON stated R53 had let go of the handles during the transfer using a sit to stand lift. The DON confirmed R53 had let go of the handles during the transfer and felt that was the cause of R53's fall. The DON confirmed R53 had been using a universal sling,	PROVIDER OR SUPPLIER 245265 245265 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 On 6/6/18, at 8:59 a.m. R53 was seated in her wheelchair while nursing assistant (NA)-G wheeled R53 to her room. At that time facility restorative nursing assistant (RNA)-A entered R53's room to assist with transfer. NA-G donned a transfer belt across R53's torso, RNA-A placed a pivot disk, (assistive device used to assist residents to pivot transfer with assist and ease) on the floor in front of R53's wheelchair. NA-G placed her foot on the pivot disk and assisted R53 to stand, while RNA-A cued R53 to turn with her foot. R53 was able to pivot with the use of the disk, turned and sat on the edge of the bed when cued by RNA-A. On 6/6/18, at 7:06 a.m. licensed practical nurse (LPN)-C stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen bars of the lift and had slid through the siln gand onto her buttocks. LPN-C stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen once since her admission a few months ago. She stated R53 had fallen with sit to stand lift, staff used the FBL until R53 was able to assist with transfers. On 6/7/18, at 2:46 p.m. R53's medical record and fall incident on 5/16/18, were reviewed with the director of nursing (DON) and the facility safety officer/educator (SO)-A. Th	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	brand of sit to stand not offer sizes of sit. However, she indic sized slings. The D diagnosis of malnusized woman. The record lacked a con R53's fall from the which would have if factors, a root caus assessment and fashe would expect the during a lift in order resident during a tracility did not have residents using the stand lift were the awith a small stature R53's medical recombete whether the universappropriate size for On 6/7/18, at 2:47 been unaware of R lift. The SO-A state lifts used a universate sling was to be was raised in the ansure residents do She indicated she indicated she had spopresent at the time indicated the sling sling which had been size of size	d lifts used by the facility did mall, medium or large. ated the facility's FBL's had ON confirmed R53 had a trition and felt she was a small DON confirmed R53's medical mprehensive assessment of sit to stand lift on 5/16/18, included potential causative analysis, post fall ll risk assessment. She stated he slings to be tightened for the sling to secure the ansfer. The DON stated the a formal system for ensuring universal slings for the sit to appropriate size for residents a Further, the DON confirmed and lacked documentation sal sling had been an	F 689			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06/	08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	, 50		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 689	had then let go of the slid through the slim. On 6/8/18, at 9:38 a universal sling used lift did not fit R53. Nowery forgetful and withe lifts handles for stated the FBL's has residents were to be appropriate sling. On 6/8/18, at 11:11 coordinator (RNCC for assessing reside the resident's ability direction, weight and stated she felt the unany not have fit he contributed to her fits/16/18. On 6/8/18, at 11:16 been on duty the day stated the NA straps of the sling and lifted her from stated R53 had the slid through the slimbeing tightened. On 6/8/18, at 11:45 was conducted with representative from Tool) Health Syster stand lift utilized by facility used a universide and he was not a lift utilized by facility used a universident lift and he was not a lift and	ne handles of the lift and had ag. a.m. NA-G stated she felt the d with the facility's sit to stand IA-G stated she felt R53 was would not be able to hold onto long without verbal cues. She ad various sized slings and	F 68	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	1 00.	30,2313
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	universal sling. He responsibility to enappropriate fit for restated the sling strathe resident was lift the sling. He stated through the universithen the sling was review of an undar Volaro PA600/PA60 applying the sling primportant part of the patient safety. The tighten the straps of was in the lift to kee A facility policy title 5/18/18, identified it identify residents a interventions to president and required and hemiplegia (or identified R56 had impairment and rectwo staff for ADL's transfers. The MDS since the last quarter R56's CAA's dated required assistance.	stated it was the facility's sure the sling was an esidents. The representative ap was to be tightened while ted to prevent sliding through the felt if a resident slid sal sling after it was tightened, not safe to use. Ited operator manual for the 20S sit to stand lift, identified properly was the most be lifting experience to ensure manual instructed staff to of the sling while the patient ep the sling snug. Id., Fall Prevention, revised the was the facility's purpose to the trisk for falls and to initiate event falls. Use of mechanical lifts and ed and not provided. In State of State of State of the sling while the patient event falls. In State of mechanical lifts and the deal of the sling while the patient event falls. In State of mechanical lifts and the diagnoses emia, congestive heart failure the sided paralysis.) The MDS bilateral upper extremity quired extensive assistance of including bed mobility and Stidentified R56 had no falls	F 689			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06	/08/2018
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP COD 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	•	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	assist R56 when sh staff were not famili indicated R56 had a R56's fall risk asses she was at risk for R56's care plan revwas at risk for falls assistance of two falls assistance of two falift for transfers. R56's incident deta revealed R56 had a stand lift and one fabed to the bathroor the NA turned the libathroom the lift tip lowered to the floor identified the wheel report revealed the manager had immesservice and biomed The report revealed transfer with two streport did not identified been open or consistent of the aforementioned serial number A870 had a broken bolt of wheel. On 6/4/18, at 1:57 pa while back from a strength of the stand lift staff the aforementioned serial number A870 had a broken bolt of wheel.	ne was not feeling well or if the iar with her. The CAA no recent falls. ssment dated 5/9/18, identified falls. vised 5/17/18, identified R56 and required extensive acility staff and the sit to stand lils report dated 11/217, been transferred with a sit to acility staff assistance from her in. The report revealed when lift to maneuver it into the sped to the left and R56 was	F 68	9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		245265	B. WING			06/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 5652			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		
F 689	with transfers with the follow up interview of stated she could not sit to stand lift were tipped over. On 6/6/18, at 7:19 at transfer from the to and NA-D. While NR56 from the toilet, the sling. NA-D the toilet, while both leg position, NA-D mar to R56's wheelchair. On 6/6/18, at 9:37 assistance with transfer a sit to stand lift. NAR56 when the lift tiphad been transferri bathroom and had extended in order for the recliner. NA-H sa a standing position wheel broke and the On 6/6/18, at 2:28 properation Manager notified when the si staff transferred R5 and secured the caunderstand how the POM-A indicated he not have been in the too much pressure stated the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the legs to the opened while moving the state of the state of the legs to the opened while moving the state of the state	he sit to stand lift. During a on 6/7/18, at 8:58 a.m. R56 of recall whether the legs of the opened at the time the lift had a.m. R56 was assisted to illet to her wheelchair by NA-FA-D used the lift controls to lift NA-F tightened the straps of a pulled the left away from the gs of the lift were in the open neuvered the lift from the toilet	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		Of	6/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		3.00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	the DON. The DOI during a transfer we confirmed R56's in analysis and comp R56's fall on 11/2/report did not identified been opened sit to stand lift, and would be a key controot cause of the seconfirmed she had to discuss any other have caused the libolt to break. The whether all of the opereventative maintained the incident with the incident with the program for mechal complete preventative check completed them all Review of an undate Volaro PA600/PA6 the legs of the lift when maneuvering manual indicated the were not in the open A facility policy titled.	ed 11/2/17, were reviewed with N confirmed R56 had fallen with a sit to stand lift. She acident report lacked a thorough prehensive assessment of 17. The DON confirmed the tify whether the legs of the lift during the maneuvering of the disconfirmed the information apponent in identifying potential sit to stand lift tipping over. She I not spoken with maintenance are potential factors which may fit to tip and/or the wheel castor DON stated she was not aware other lifts in the facility had renance completed following the sit to stand lift used with R56. 2 a.m. the facility biomedical facility had a maintenance anical lifts, which indicated to ative maintenance every two I manager indicated he had not going two years between as on the lifts, therefore he innually. Atted operator manual for the oos sit to stand lift, identified were used for stabilizing the lift of a patient in the lift. The he lift would tip over if the legs an position.	F6	89		
	5/18/18, identified	it was the facility's purpose to at risk for falls and to initiate				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG	COMPLETED
		245265	B. WING _		06/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLÉTION
F 689	Continued From pa	ge 23	F 68	39	
	slings was requeste	use of mechanical lifts and ed and not provided. Status Maintenance 1)-(3)	F 69	02	7/24/18
	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas	essment, the facility must			
	of nutritional status desirable body weig balance, unless the	tains acceptable parameters , such as usual body weight or ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise;			
	§483.25(g)(2) Is off maintain proper hyd	ered sufficient fluid intake to dration and health;			
	there is a nutritiona provider orders a th	ered a therapeutic diet when I problem and the health care perapeutic diet. NT is not met as evidenced			
	Based on observat review, the facility fa assess and provide	tion, interview and document ailed to comprehensively didentified interventions for 1 reviewed with a significant		Super high calorie cereal was ad at breakfast, 2oz. Ensure compact supplement added at all medicati passes (4x/daily), continued with restorative assisted eating prograquiet and low stimulus eating	et on
	Findings include: R1's discharge retu	rn-anticipated Minimal Data		environment, and fortified milk ad place of regular 2% milk for drink purposes, staff to try soft music a	ing

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245265	B. WING			06/0)8/2018	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		.0,2010	
OT 50 44	1010 110145			24	400 ST FRANCIS DRIVE			
SIFRAM	ICIS HOME			В	RECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	Set (MDS) dated 4 diagnoses which in disorder and diabe identified R1 requir weight of 96 pound (percent) or more in or more in last 6 m record documented pounds, which reprin weight with a greathe last month. R1's significant chat MDS dated 5/16/18 impaired cognition assistance from stat (ADLs) which incluidentified diagnose diabetes mellitus, a disorder and glaucidentified a weight diet and a weight diet and a weight diet and a weight of months. R1's nutritional stat (CAA) dated 5/25/18 month or loss of 10 months. R1's nutritional stat (CAA) dated 5/25/18 pounds, which was February 2018, R1 psychiatric stay and indicated R1's average was poor. Staff we powder with each (untritional supplem no further weight loss.	age 24 /24/18, identified R1 had icluded anxiety, psychotic ites mellitus. The MDS red supervision with eating, is and no weight loss of 5% in the last month or loss of 10% onths. However, R1's clinical da weight on 3/24/18, of 101.8 resented a significant change reater than 5% weight loss in ange in status assessment B, identified R1 had moderately and required extensive aff for all activities of daily living ded eating. R1's MDS s which included: dementia, anxiety, depression, psychotic oma. R1's MDS further of 98 pounds, a therapeutic oss of 5% or more in the last of 98 pounds, a thera	F6	692	holding during meal times for appetis stimulation. Residents that triggered with a signiweight loss, will have a comprehens assessment take place and nutrition interventions will be implemented an adjusted accordingly. Monitoring an evaluating the interventions will be oweekly at IDT meeting. Verbal education on appropriate nutinterventions relating to weight loss conducted at daily Safety Huddles foweek. Written education will be poseach neighborhood and staff are rectosign off that they have read and understood the changes. Additional training will be conducted with all staduring the annual Skills Day training month. PRN staff will receive education material via mail with a signature pathat must be returned stating that the have read and understood the chance and understood the chance will be discussed again care conferences. Audits will be conducted 3 times per week for 4 we and then once per week until QAPI meeting on residents with significant weight loss to determine that the nutritional interventions have been implemented and evaluated. A performance improvement will will be completed and reviewed at next QA meeting. Monitoring will continue unconsecutive months of compliance in the complia	ificant sive hal hid		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 692	Review of R1's Die 5/25/18, indicated a considered high ris R1's Resident Care as R1's significant assessment, dated was 98 pounds and 112 pounds, a decrindicated R1 was onutritional supplement powde each glass of milk anutrition drink mix pday. The form indicassistance at meals further indicated mincluded 3 breakfas and 4 supper meals at 0% or refused ar per day. The noted possible reasons for considerations and prevent further weight as a required to eat for cues and observone staff as indicate cognitive deficit. R1 R1 left 25% or more meals and had poor intake as well as a resulting weight los	tary Risk Assessment dated a risk score of 13, which was k. c Conferences form, identified change nutritional 5/24/18, indicated R1's weight I weight last conference was ease of 14 pounds. The form in a regular diet and received ent Pro-Pass (whey protein in provides 30 calories) with and Juven (therapeutic provides 95 calories) twice a lated R1 required set up is with coaching. The form eal intakes for R1 which ests at 85%, 2 lunches at 25% is at 50% with all other meals and fluids at 755 milliliters (ML) lacked further analysis of or R1's weight loss and interventions to attempt to	F 692	been attained. Responsible: DON and Director of Nutrition Services	of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	, 30	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 692	will not decline any record. R1's care p intake and weights, meal replacements ordered, provide a environment at meaphysical assist with nursing assistant week, and R1 dran mealtime/try to recoffer protein powder R1's nursing assist 6/1/18, indicated R room, however, lack regarding R1's nutrinterventions. On 6/6/18, at 11:42 to sit at a dining rood dining room. R1's pof milk, glass of war mashed potatoes, owas seated across two other residents looking around the another NA sat at the assisted another reup small pieces of taking small bites, and had consumed bite in her hands a without attempting independently stoof for her walker, and had consumed bite	further, as indicated by weight lan directed staff to monitor provide a regular diet, offer and snacks, supplements as quiet and low stimuli altime, provide cues and eating as needed, restorative ill assist with 3-5 meals per k excess amounts of milk at lirect to eat solid foods and with each glass of milk. ant (NA) Care Sheet updated 1 ate in the assistance dining cked any further directions ition needs or nutritional a.m. R1 was assisted by staff om table in the assistance blace setting included a glass ter, a plate with pork roast, corn and sweet potato. NA-B the table from R1 assisting to eat. R1 was not eating, but full dining room. At 11:49 a.m. he table to the left of R1 and sident to eat. R1 was picking bork with her left hand and along with small sips of water. as observed to take small all bite of corn and small sip of would pick up a piece of pork, and place it back on her plate to eat. At 12:13 p.m. R1 d up from her chair, reached walked back to her room. R1 s of corn and pork and drank nces of milk and water. No	F 69	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 692	R1 to eat, or assist entire observation. On 6/7/18, at 8:36 a independently with in the assistance diremained seated aresidents in the rooglass of milk with Pher on the table. At attempted to take at the kitchenette and which consisted of and two pieces of plead (AA)-L sat nex tried to give R1 a bher mouth. AA-L plmilk and attempted her milk, R1 would proceeded to offer a bite of toast, with take bites of the ite times to get R1 to the success and gave a.m. AA-L transferr brought her back to sips of milk and two AA-L did not offer a alternatives during. On 6/7/18, at 11:22 back in bed with eye continued the same eating the lunch me walked by R1's room food items to a resire.	neal substitute, encouraged ed R1 with her meal during the a.m. R1 walked down the hall her walker and sat at a table ining room. At 8:39 a.m. R1 to the table looking at other om. At 8:45 a.m. staff placed a pro-pass mixed into it in front of a drink of milk. AA-L went to a small bowl of applesauce ellied toast. activities assistant at to R1, cut up the toast and ite of toast. R1 would not open aced a straw in the glass of a spoonful of applesauce, and R1 refusing to consistently ms. AA-L tried multiple more take a bite of the toast without ther another sip of milk. At 9:07 and R1 to a wheelchair and on her room. R1 had consumed to small bites of applesauce. The breakfast meal. Ta.m. R1 was lying on her are closed. At 11:47 a.m. R1 are as other residents were all in the dining room. NA-A m as she delivered a tray of ident in the hall across from not stop. At 12:14 p.m. R1 and on her back and no staff	F 693	2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 692	entered R1's room, recliner, sat next to a glass of milk and On 6/7/18, at 2:17 pthrough the lunch in hard to get R1 to si would sit, she woulstated R1 returned stay in May and get than before. She st glasses of milk at esips of milk. On 6/7/18, at 2:27 pvery weak and very the inpatient psychistated R1 had to be meals, got up from meals and wanders the nurse must have lunch, otherwise she dining room. On 6/10 up interview, NA-A then no we don't way what the nurses tolon on 6/7/18, at 2:32 pinpatient psychiatric when she came bad different person. The some medications she wanders a lot at NA-D stated if staff eat, then R1 would	assisted her to transfer to her assisted her to transfer to her assisted her to drink eat one cookie. D.m. NA-D stated R1 slept neal. NA-D stated R1 was tand eat a meal and if she donly eat a few bites. NA-D from an inpatient psychiatric ting R1 to eat had been worse ated R1 used to drink 3-4 each meal and now only drinks on. NA-A stated R1 was tired, of different after returning from a tric hospitalization. She accued to eat and drink at dining room chairs during ed between units. NA-A stated the directed not to get R1 for the would have been in the [8/18, at 9:00 a.m. in a follow stated, "if [R1] is sleeping, ake her up, at least that is	F 69.	2		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06	/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 692	staff were to offer I and then could cha 6/8/18, at 9:12 a.m NA-D stated she have regarding nutritional restorative nursing manager including. On 6/7/18, at 2:47 (LPN)-A stated R1'R1 would only take stated R1 loved mimilk and give her cand with meals. LF Juven twice a day. tried sitting R1 facione item of food at from the table and confirmed no staff lunch meal. LPN-A was currently at 93 to R1's psychiatric aggressive and wo the facility and now would still eat about On 6/7/18, at 2:57 a trained medication dining room every stated she tried to morning and stated other menu items a sips of milk or refusions.	R1 her meal a couple times art a refusal of the meal. On . during a follow up interview, ad not received education al interventions from the program or the nurse to offer finger foods. p.m. licensed practical nurse s appetite was very poor and a couple bites at meals. She lk and staff add Propass to me with each medication pass PN-A stated R1 also received LPN-A stated last week staffing the window and gave her a time, but she still got up only ate 25%. LPN-A attempted to wake R1 for the stated R1 had lost weight and stated R1 had lost weight and stand near the exit door to R1 was more dosile, but at the same amount. p.m. AA-L stated she was also on aide and assisted in the morning she worked. She get R1 to eat breakfast that d she had not offered R1 any after the bites of apple sauce, sal of toast.	F 6	992			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	06/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIES (ENCY)	JLD BE	(X5) COMPLETION DATE	
F 692	6/4/18, revealed: -March 1-31, 2018, 100% of the meal 6, 75% of the meal 3, 50% of the meal 1, 25% of the meal 23, 0% of the meal 29, 18, Refused the meal 3	ands ands ands ands ands ands ands ands	F 69	92			
	-April 1-24, 2018, R	11 consumed:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06.	06/08/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ST FRAN	ICIS HOME			2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 692	Continued From pa	ge 31	F 6	92			
	(MAR) from 3/1/18, started ProPass on 5/10/18, which R1 in Review of R1's pro-6/4/18 revealed: -5/9/18, R1 was we	time times times times times times 28 times 1 consumed: times time times times times times times times times times time times t					
	-5/10/18, R1 did no	t want breakfast, ate some					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING_		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 692	lunch, but not muce (DM) to start on Ju-5/11/18, R1 refused -5/12/18, R1 slept 101.4 pounds. -5/14/18, ate fair for anything for breakth -5/17/18, R1 continuation of the start of the sta	h. Order from dietary manager oven supplements twice a day. ed to eat. past breakfast. Current weight or lunch and refused to eat fast. nued to eat poorly. R1's physician on varied average of 25% at meals. ounds. R1 continued to needing and drinking and needs to encouraged to eat and drink. through supper. ttle for breakfast, had Propass aven at 1000. ht was 93.5 pounds. d nursing are working on a less here for her to eat at meal p.m. director of nutrition stated she was a dietician, but onsultant for the facility. She aware R1 had lost that much ted the dietary supervisor e dietary program at the facility have tried interventions prior to	F 69			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06	/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	inpatient psychiatric medications had be started due to deco DS-A stated R1 gain hospitalized, but has he stated R1 was wandered a lot. DS drinking milk like sh cookies as much a trialed other juice a well as high calorie past without successinterventions had n since the recent significated since R1 hospitalization, staff assistance dining repropass in each m started working on eating program to compare the recent significated since R1 hospitalization, staff assistance dining repropass in each m started working on eating program to compare the district of the propassion of the recordinator (RNCC) weight loss was first continued until an inhospitalization. Whabout 5 pounds, but losing weight again non-stop movemer and fluids on the recordination of the rec	o.m. DS-A stated R1 had an estay and when she returned een decreased and therapy onditioning while hospitalized. In the state of the st	F 69	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETION DATE
F 692	environment with s needed. She state made some medical Juven and family be at the point that she RNCC-B stated R1 cueing and up to to indicated she would encourage and assemenu options at easif R1 was not eating. On 6/8/17, at 11:17 interview, DNS-A stost weight, but was significant change a long standing proindicated she did non utritional assessmenot asked to do so assessed R1's labs diagnoses and ther interventions, inclusively lements and discressful or not. On 6/8/18, at 11:43 stated R1's gradual March. R1 had a penot calm down. Nur R1's medications, it continued to declining inpatient psychiatric 5/9/18. DON indical better after her returned to determine the return of the state	low stimulated meal taff cueing and assisting as d R1's physician recently ation adjustments, added rought in Oreo's, but now was e no longer liked Oreo's. required supervision and tal assistance for eating. She d have expected staff to cue, list R1 with intake, offer R1 all lich meal and offer alternatives g what was served. Ta.m. during a follow up tated she was aware R1 had a not aware of R1's recent in weight and indicated it was blem to get R1 to eat. DNS-A or routinely complete resident tents unless DS-A asked for she had not completed a not for R1 at any time, and was She indicated she would have a, medications and specific	F 692			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 692	feeding her on the gorder supplements nutritional status are she would have expositive after a couploss. She stated shan assessment from assistance with intervould have expected assist R1 as needed items and alternative inappropriate to not sleeping during a management of the state of the s	wn to eat and staff should be go. DON expected dietary to add snacks, monitor R1's id intake closely. DON stated bected the dietician to be ble weeks of identified weight e would also have expected in the dietician and to provide exventions. DON indicated she ed staff to cue, encourage and diduring a meal, offer all menuices and stated it would be try and wake R1 if she were neal.	F 69	2		
F 880 SS=F	residents at nutritio weight loss would haddressing it. A sysinterventions would areas are addressed nutritional supplementages to take to incompare to incom	control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the cansmission of communicable	F 88	0		7/18/18

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING _		06	/08/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	•		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	SHOULD BE COMPLÉTIO		
F 880	program. The facility must es and control program a minimum, the foll §483.80(a)(1) A system of surface and communicable staff, volunteers, visproviding services arrangement based conducted accordin accepted national staff. Writter procedures for the but are not limited to (i) A system of surver possible communication infections before the persons in the facili (ii) When and to who communicable diserported; (iii) Standard and the to be followed to provide (iii) When and how it resident; including to (A) The type and do to the standard and the total control of the standard and t	n prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other tty; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a out not limited to: uration of the isolation,	F 88	,			
	involved, and (B) A requirement to least restrictive postircumstances. (v) The circumstance	e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED		
		245265	B. WING _		06/0	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A systematical system of the corrective actions to §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual of the corrective actions to line system of the facility will confine the corrective actions. §483.80(f) Annual of the facility will confine the second update the facility will confine the ensure tracking and and illness in the facility for the ensure tracking and and illness in the facility. In additing a Legionella prograssion of the ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and and illness in the facility failed to ensure tracking and the facility failed t	skin lesions from direct hts or their food, if direct t the disease; and he procedures to be followed direct resident contact. In the disease is and he procedures to be followed direct resident contact. In the disease is and he procedures to be followed direct resident contact. In the disease is and he procedures is a facility is a facility is a facility. In the disease is and a facility is a facility is a facility. In the disease is and a facility is a f	F 88	Ensure Tracking & Trending for illness and infections: Facility developed and implement racking and trending form for all viral illness and infections. Will illness tracking form for trends are appropriate action for prevention spreading viral illness. Will also proximity of ill residents to health residents. Facility implemented a and trending form for all potential illness and infections. Verbal econ reporting/tracking potential virillness/infections will be conducted and staff are requising off that they have read and	ted a potential monitor nd take of monitor y tracking resident ducation al ed at daily	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245265	B. WING			06/0	08/2018
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	A review of the facili was conducted on director of nursing of provided copies of Charge Sheets from listed daily various hospital returns addiversed follow up follow up listed varidiagnosis of pneum failure, increased some Coumadin (blood the or increase in antice change in use of more form listed R9 had productive cough a influenza A. and had 4/2/18. On 4/4/18, influenza and had be symptoms. There we had reported this sed department of health. The DON stated the charge sheet forms resident viral infection for resident viral infection for resident viral infection for resident viral illust the end of the more the antibiotics used month, and did not viral illness. She stappogram was informed the facility. DON discussed antibiotic however, the policy still in draft form at	lity's infection control program 6/8/18, at 12:03 p.m. with the (DON) present. The facility daily forms titled: 24-Hour n 4/1/18 to 4/8/18. The forms items such as hospitalizations, missions, and residents who The residents who required ous reasons such as items of breath, change in inner medication) orders, start depressant medication, or echanical lift. On 4/1/18, the attemperature of 99.4, and had tested positive for dispersion been started on Tamiflu on R9 had been tested for peen treated for a respiratory was no evidence the facility uspected outbreak to the	F &	380	understood the changes. Additional training will be conducted with all stight during the annual Skills Day training month. PRN staff will receive educe material via mail with a signature pathat must be returned stating that the have read and understood the charmone Staff have been educated at daily have report all resident and staff illnes the charge nurse, DON or Infection Preventionist. Charge nurses, DON Infection Preventionist will then repubased on MDH/CDC recommendate. All illness are now tracked and more every shift looking for trends and reportable illnesses. A perfomance improvement plan will be implement and reviewed at next QA meeting. Monitoring will continue until 4 consecutive months of compliance been attained. Responsible: DON Influenza Outbreak Reporting Facility will report all positive Influer results to the appropriate state and authorities. Residents will be identification on reporting all positive influenza to state and local authorities conducted at daily Safety Huddle week. Written education will be positive influenza to state and local authorities conducted at daily Safety Huddle week. Written education will be positive influenza to state and local authorities and monitoring and staff are reto sign off that they have read and understood the changes. Additional training will be conducted with all stight during the annual Skills Day training month. PRN staff will receive eduction education education.	aff g this ation age ney nges. nuddles ses to N or ort ions. ntitored ated have neg local fied by fected Verbal fies will es for 1 sted on quired aff g this	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	08/2018	
NAME OF F	PROVIDER OR SUPPLIER	2	·	STREET ADDRESS, CITY, STATE, ZIP C			
				2400 ST FRANCIS DRIVE			
STFRAN	ICIS HOME			BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Review of the facil Prevention and Corevealed there wo infections among infections that occ facilitate recognition well as clusters and Review of the facil Management, revifacility would condreport the outbreal local authorities. Review of the Minform titled Long Terms (2017-1) laboratory confirm along with other caunit. Legionella On 6/6/18, at 6:55 pond was made of entrance. The port parking lot and had the fountain sprayair. At 7:15 a.m. during courtyards were of the facility would condreport the outbreat local authorities.	lity policy titled, Infection ontrol Program, revised 12/17, uld be ongoing monitoring for patients and documentation of ur and systems in place to on of increases in infections as ad outbreaks. lity policy titled, Outbreak sed on 2/16, revealed the uct outbreak monitoring and k to the appropriate state and the end of the facility Influenza and 18, defined an outbreak as one ed influenza positive case ases of respiratory illness in a sea. In a conservation of a large of the facility's main and was adjacent to the facility's did a large fountain in the center. It is a large fountain in the center of the facility tour, multiple of the facility	F8	material via mail with a sign that must be returned statin have read and understood to a september, all staff will be the flu season and our reportequirements. DON or Infer personnel will report all influed MDH. Influenza cases will a reported at QA. Responsibility oxygen tubing & nasal cannown All staff were educated via the board and daily huddles x 1 oxygen tubing/nasal cannown as to red off the floor for contal prevention. Also discussed or nasal cannown a brand new one. Resident nasal cannown as the completed weekly times 4 were provided to ensure the tubing cannown as positioned approximate to ensure the tubing cannown as positioned approximate to ensure the tubing cannown as positioned approximate to ensure the floor. Verton proper storage/handling tubing/nasal cannown will be daily Safety Huddles for 1 weducation will be posted on neighborhood and staff are sign off that they have read understood the changes. A training will be conducted we during the annual Skills Day month. PRN staff will receive material via mail with a sign	g that they he changes. e reminded of rting ction Control enza cases to also be le: DON hula storage he huddle week that a s must be mination if the tubing he floor it d replaced with #52 that had ow has hers will be yeeks and then oxygen g/nasal priately and bal education of oxygen conducted at reek. Written each required to and dditional ith all staff or training this ye education		
		cility's Legionella program was 18, at 12:40 p.m. with the plant		that must be returned statin have read and understood t			

CLIVIL	13 I OIT WILDICAIL	A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		E SURVEY PLETED
		245265	B. WING			06/0	08/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				24	400 ST FRANCIS DRIVE		
ST FRAN	ICIS HOME			В	RECKENRIDGE, MN 56520		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
F 880		nge 40 er (POM)-A present. POM-A	F 8	380	PDSA worksheet for testing chang	e will be	
		ent of their campus for water			completed and a performance	o wiii bo	
		not been conducted. He stated			improvement plan will be implement	nted	
		r water management had not			and reviewed at next QA meeting.		
		d was only in draft form at			Monitoring will continue until at least	st 3	
		he checked the water weekly			consecutive quarters of compliance		
	for chlorine levels,	and he felt if the chlorine levels			been demonstrated. Responsible:	DON	
		water was acceptable. The					
		he facility had several water			Legionella Program		
		urtyards of the facility that had			Our Water Management Plan has		
	not been monitored and not been assessed for potential concerns with Legionella. The POM-A				revised with DRAFT removed from		
					policy and to include Legionella tes		
		the draft policy for review at er Management Policy, dated			twice a year in affected areas. Unti samples can be tested, all fountair		
		old letters on all pages of the			been drained and taken out of serv		
		draft policy listed examples			The revised policy will be applied to		
		water quality in various areas			affected areas.	o un	
		raft policy did not include			Semi-annual testing for Legionella	has	
		r areas in the facility for			been entered into our work order		
		not include directions for that			management system which will		
	monitoring.				automatically trigger when the testi		
					needs to be performed. Complian		
		titled, Water Samples Free			be tracked through this system and	t	
		3/18 to 6/5/18, revealed a water			reported to QAPI annually.		
		ested from a random room in			Deepensible: Feeilit: Menere		
		care and acute care center of			Responsible: Facility Manager		
		r. However, the form lacked any further testing, or					
		entative measures done to					
		egionella to grow or spread.					
	Davious of malian	rouided by the feetlite titled					
		rovided by the facility titled					
		onnaires Disease, dated 1/18, nent program would identify					
		g where Legionella could grow					
		determine the control					
		plied, and implement					
		ring of the areas to prevent the					
		of Legionella. The policy listed					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245265	B. WING_		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	various locations w heaters and public policy did not identi decorative water fo	nge 41 hich included showers/sinks. water mains. However, the fy the multiple facility untains, and did not include or the decorative water	F 88	30		
	5/8/18, revealed R5 cognition and had opulmonary heart dianxiety. The MDS a independent with a	nimum Data Set (MDS) dated 52 had moderately impaired diagnoses which included sease, heart failure and also indicated R52 was ctivities of daily living (ADL's), n of one staff with transfers and erapy.				
	5/23/18, revealed F two liters per nasal per day during ever	ed physician orders dated R52 had an order for oxygen at cannula at night, two times ning and night. Oxygen tubing er day every 14 days during				
	(EMAR) was review revealed R52 was	ronic Medication Record ved from 5/18 to 6/18, currently receiving oxygen at cannula at night two times per and night.				
	5/17/18, indicated Instability related to heart failure and costent placement. R	rrent care plan revised on R52 was at risk for cardiac hypertension, congestive bronary artery disease with 52's care plan listed various ncluded oxygen as needed s.				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245265	B. WING _		06	/08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	During observation was seated in her wher bed. A oxygen located on the right recliner. The oxyge oxygen tubing was unit and the tubing observed curled up night stand next to -At 1:25 p.m. nursing the room, and step tubing and nasal caproceeded to put a waist, assisted R52 transferred R52 frowhile continuing to and nasal cannula of her night stand. Bed by herself while R52's closet for her continuing to an	s on 6/4/18, at 1:24 p.m. R52 wheelchair in her room next to wall unit with bubbler was a side of the wall above R52's in wall unit was running, the connected to the oxygen wall and nasal cannula were on the floor in front of R52's her bed. In gassistant (NA)-A entered ped directly on the oxygen annula with her shoes. NA-A transfer belt around R52's to a standing position and im her wheelchair to her bed walk on R52's oxygen tubing while it laid on the floor in front R52 proceeded to lay down in a NA-A got a pillow case out of r pillow. Asked the NA-A about her hed down to the floor, picked bing and nasal cannula off the to R52. R52 took the oxygen the nasal cannula part of the ner nostrils and wrapped the ears independently. R52's gat two liters per minute and oxygen connector was dated 5/2	F 88			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				JLTIPLE CONSTRUCTION DING		E SURVEY PLETED
		245265	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	with her oxygen tube to both of her nostreliters per minute and connector was date. During observation was laying in bed reand nasal cannula with oxygen running the plastic green oxwith a black marke. On 6/5/18, at 2:41 jutilized oxygen who confirmed the oxygen was lying on the flonot gotten new oxy R52 after it had been walked on. NA-A in that she had stepped lying on the floor are new one (tubing)." On 6/7/18 at 9:46 at (RC)-A confirmed F was feeling short on needed during the indicated the oxygen should be changed practical nurses an EMAR. The RC-A is staff to change R52 cannula when it was staff walked on it. Further tubing and nasal carright away. On 6/7/18 at 3:35 per connection of the staff walked on it. Further tubing and nasal carright away.	ping and nasal cannula applied ils with oxygen running at two id the plastic green oxygen ed 5/2 with a black marker. s on 6/5/18 at 8:51 a.m. R52 esting with her oxygen tubing applied to both of her nostrils g at two liters per minute and aygen connector was dated 5/2	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245265	B. WING			06/0	08/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	expect staff to throw tubing away and to	w the contaminated oxygen get a new one.	F 8	30			
	Therapy revised on	ty policy titled, Oxygen 3/13, indicated nasal cannula ans will be changed every two n if visibly soiled.					

PRINTED: 07/10/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - MAIN BUILDING 245265 B. WING 06/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2400 ST FRANCIS DRIVE ST FRANCIS HOME **BRECKENRIDGE, MN 56520** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey St Francis Home 01 Main Building 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

07/06/2018

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING 02 - Main Building		COMPLETED	
		245265	B. WING_		06	/05/2018
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	E	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MU FOLLOWING INI 1. A description of to correct the definition of the correct the correct the definition of the correct the correct the definition of the correct the correct the correct the correct the correct the correct the definition of the correct the definition of the correct the definition of the correct the co	al Division treet, Suite 145 D1 Distate.mn.us Distate.mn.us DIST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done iciency. Distate.mn.us DIST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done iciency. Division of the person correction and monitoring to rence of the deficiency. Division of the St Francis ous. It was built in 2005, is a without a basement and was Type V (111) construction. It is of Francis Healthcare Center with the strand is divided into 4 smoke				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED				
		245265	B. WING_		06/0	05/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 211	throughout the corrithe corridors, and considers, and considers are should be sufficient to system has been in NFPA 72 "The National Hazardous areas had that are connected all sleeping rooms halarm outside the restation that serves to station that serves that serves to station that serves the serves	a system with smoke detectors idor system, in areas open to common areas. The Fire Alarm estalled in accordance with onal Fire Alarm Code". ave automatic fire detectors into the fire alarm system and have smoke detectors that coms and at the nurse's that room. The facility is considered apacity of 80 beds and had a time of the survey. 42 CR, Subpart 483.70(a) is General General General General General The facility is considered apacity of 80 beds and had a time of the survey. The facility is considered apacity of 80 beds and had a time of the survey. The facility is considered apacity of 80 beds and had a time of the survey. The facility is considered apacity of 80 beds and had a time of the survey.	K 00			7/6/18
	full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1.1 This REQUIREMEN by: Based on observat interview, the facility unobstructed acces required by the Life 2012 edition section	10.1 NT is not met as evidenced tions, record review and staff		All wheelchairs and lifts have been removed from the exit areas and st other areas. Education performed through daily safety huddles throug 6 with staff to keep all exits cleared supplies and equipment.	tored in th July	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING 02 - MAIN BUILDING						
		245265	B. WING_		06/	05/2018
NAME OF PROVIDER OR S ST FRANCIS HOME	UPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
These defices ability of an staff and vision of the facility on 06/05/20 chairs and at the intersect documental inspections months. These defices facilities Misser of the facilities Misser of the facilities Misser of the facilities of the facili	Dpening ient pra undete sitors. Slude: ity tour 18 obs a lift we tion of sion rev were n ient colanager. Areas - PA 101 Areas - areas a ur fire roors) or coordan pproveon is us for the door be selfed to hallates that tom of e floor a selfoor a floor a fl	p Protective's 2010 edition. actices could affect the exiting rmined amount of residents, between 8:00 am to 12:00 pm ervations revealed wheel re being stored in the exit at areas G & F and iew revealed the fire door ot conducted in the last 12 anditions were confirmed by the Enclosure Enclosure Enclosure Enclosure an automatic fire extinguishing are with 8.7.1 or 19.3.5.9. If automatic fire extinguishing and automatic fire extinguishing and automatic fire extinguishing and automatic fire extinguishing are with 8.7.1 or 19.3.5.9. If automatic fire extinguishing are made of the areas shall be also shall be also shall be areas shall be area	K 21	Responsible: Facility Manager	N N	7/6/18
19.3.2.1, 19 Area		nat are deficient in REMARKS. Automatic Sprinkler				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G 02 - MAIN BUILDING		E SURVEY PLETED
		245265	B. WING_		06/0	5/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 321	c. Repair, Maintena d. Soiled Linen Roc e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if c Hazard - see K322) This REQUIREMEN by: Based on observat facility to maintain a accordance with the (NFPA 101) section condition could allo corridor making it u	Fired Heater Rooms I than 100 square feet) Ince, and Paint Shops Ims (exceeding 64 gallons) Rooms Ins) Insert Rooms Ins Insert Rooms Ins Insert Rooms Ins Insert Rooms Insert R	K 32	All items not directly related to the washing of wheelchairs has been removed from this area. Room ha restored to it's intended purpose. Reponsible: Facility Manager	s been	
	on 06/05/2018 obsewas initially a wheel to storage and did rwith a 45 minute rate. These deficient confacilities Manager. Evacuation and Rel CFR(s): NFPA 101	ditions were confirmed by the ocation Plan	K 71	1		7/18/18
		ocation Plan lan for the protection of all ir evacuation in the event of				

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 1 02 - MAIN BUILDING		PLETED
		245265	B. WING		06/0	05/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 712	informed with their copy of the plan is reported or with section and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 th 19.7.2.2, 19.7.2.3 This REQUIREMEN by: Based on record refacility failed to main required in NFPA 10 edition section 19.7 could cause confus affect all 80 residen amount of staff and Findings include: On the facility tour be on 06/05/2018 document of the fire safety plan of 1. Preparation of fleevacuation. 2. No direct call to the These deficient con Facilities Manager. Fire Drills CFR(s): NFPA 101	odically instructed and kept duties under the plan, and a eadily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan /19.2.2. 7.1.3, 18.7.2.1.2, 18.7.2.2, arough 19.7.1.3, 19.7.2.1.2, arough 19.7.1.3 the telephone exists and staff interview the plan as 10 Life Safety Code, 2012 and 10 Life Safety Code, 2012 and 10 Life Safety Code, 2012 and 20 Life Safety Code,	K 711	Fire plan has been revised as of 7-to include preparation of floors and building for evacuation. A section h been added to require a call to the Breckenridge Police dispatch to cor they have received our signal. Trainall employees for this new process completed by July 18, 2018. Responsible: Facility Manager	as ifirm ning to	7/2/18
	signal and simulatio					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		245265	B. WING _	B. WING		5/2018
	NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 712	unexpected times used least quarterly on exhibit procedures and established routines between 9:00 PM a announcement may alarms. 19.7.1.4 through 19 This REQUIREMENT by: Based on record refacility failed to conditions as require (NFPA 101) 2012 ed 19.7.1.7. This deficit ability of staff to corresponse to a fire exhibit on the staff of the st	s are held at expected and inder varying conditions, at ach shift. The staff is familiar d is aware that drills are part of Where drills are conducted and 6:00 AM, a coded be used instead of audible	K 7′	We have changed our work order require separate fire drills for the he and long term care. This process hin June. Training was conducted w staff regarding this new process on conditions. Responsible: Facility Manager	ospital oegan vith	
	On the facility tour k on 06/05/2018 docu the fire drills were n conditions and the c and the hospital we These deficient con Facilities Manager. Fundamentals - Bui CFR(s): NFPA 101 Fundamentals - Bui Building systems ar 1 through 4 required	petween 8:00 am to 12:00 pm amentation review revealed of conducted under varied drills for the long term care re conducted together. ditions were confirmed by the lding System Categories Iding System Categories e designed to meet Category ments as detailed in NFPA 99.	K 90	01		7/2/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING		(X3) DATE SURVEY COMPLETED	
		245265	B. WING	B. WING		05/2018
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 901	Continued From pa documented risk as performed by qualit Chapter 4 (NFPA 9	ssessment procedure fied personnel.	K 901			
	by: Based on observatifacility has failed to current facility Risk with the NFPA 99 "I 2012 edition section could affect all residundetermined number on 06/05/2018 door here was no record completed These deficient corrections Manager. Electrical Systems CFR(s): NFPA 101 Electrical Systems Hospital-grade recellocations and where anesthesia is administallation, replace testing is performed documented performed	NT is not met as evidenced tion and staff interview, the provide a complete and Assessment in accordance Health Care Facilities Code" n 4.1. This deficient practice dents, as well as an ber of staff, and visitors. Detween 8:00 am to 12:00 pm umentation review revealed of a risk assessment being nditions were confirmed by the Maintenance and Testing eptacles at patient bed e deep sedation or general nistered, are tested after initial ement or servicing. Additional dat intervals defined by mance data. Receptacles not rade at these locations are	K 914	We do a PQE Program Quality Evaluation every year. A copy of the sent to the Deputy Fire Marshall to that we have one and it is done and This was approved by the Deputy Marshall via email on 7-2-18. Responsible: Facility Manager	show nually.	7/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
	245265 B. WING			06/05/2018		
	PROVIDER OR SUPPLIER	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 914	isolation monitors (lintervals of less that actuating the LIM to which activates both LIM circuits with automanual test is performed to 12 months 6.3.3.3.2 after any relectric distribution maintained of requirepairs or modificat area tested, and res 6.3.4 (NFPA 99). This REQUIREMENT by: Based on observation the electrical testing maintained in according standards for Healt section 6.3.4. This 80 residents as well of staff, and visitors. Findings include:	ot exceeding 12 months. Line LIM), if installed, are tested at n or equal to 1 month by est switch per 6.3.2.6.3.6, h visual and audible alarm. For tomated self-testing, this ormed at intervals less than or . LIM circuits are tested per repair or renovation to the system. Records are red tests and associated ions, containing date, room or sults. NT is not met as evidenced ions and staff interview, that g and maintenance was not redance with NFPA 99 th Care Facilities 2012 edition, could negatively affect 80 of I as an undetermined number	K 914	We have begun testing all outlets nursing home. Testing includes poroper grounding and tension. A worder will be generated to test thes annually. Responsible: Facility Manger	larity, ork	
	the last 12 months. These deficient con Facilities Manager.	d of receptacle inspections in ditions were confirmed by the ylinder and Container Storag	K 923			7/2/18
55=E	Gas Equipment - C	ylinder and Container Storage all to 3,000 cubic feet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG 02 - MAIN BUILDING		E SURVEY IPLETED	
		245265	B. WING		06/	05/2018	
	NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 923	ventilated in accord 5.1.3.3.3. >300 but <3,000 ct Storage locations a within an enclosed limited- combustible gates outdoors) the gases are not store separated from consprinklered) or enconcombustible consprinklered) or enconcombustible consprinklered or equal in a single smoke of cylinders available care areas with an or equal to 300 cuts stored in an enclose handled with precard apprecautionary sign each door or gate of where the sign including minimum "CAUTION STORED WITHIN Storage is planned of which they are removed in they are removed in the open are producted in the open are	are designed, constructed, and dance with 5.1.3.3.2 and ubic feet are outdoors in an enclosure or interior space of non- or le construction, with door (or lat can be secured. Oxidizing led with flammables, and are imbustibles by 20 feet (5 feet if leosed in a cabinet of instruction having a minimum on rating. It is a solution to 300 cubic feet compartment, individual for immediate use in patient aggregate volume of less than bic feet are not required to be sure. Cylinders must be autions as specified in 11.6.2. In readable from 5 feet is on of a cylinder storage room, udes the wording as a DN: OXIDIZING GAS(ES)	K 9	Proper signage was ordere on these doors. Responsible: Facility Mana			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 02 - Main Building	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245265	B. WING06		06/	05/2018
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 923	condition could affer staff and visitors. Findings include: On the facility tour k on 06/05/2018 obsestorage rooms 880 the proper sign-age	section 11.3.4.1. This ct an undetermined amount of petween 8:00 am to 12:00 pm ervations revealed oxygen & 980 were not identified with	K 923			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 26, 2018

Mr. David Nelson, Administrator St Francis Home 2400 St Francis Drive Breckenridge, MN 56520

Re: State Nursing Home Licensing Orders - Project Number S5265027

Dear Mr. Nelson:

The above facility was surveyed on June 4, 2018 through June 8, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

St Francis Home June 26, 2018 Page 2

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 Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Downes Stappon

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 07/27/2018 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/08/2018	
NAME OF I	PROVIDER OR SUPPLIER		l .	STATE, ZIP CODE	1 00/0	0/2010
	ICIS HOME		RANCIS DR			
BRECKE			NRIDGE, MN	56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the corrected requires of requirements of the number and MN Ru When a rule contain	nether a violation has been				
	lack of compliance. re-inspection with a result in the assess	Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/06/18

TITLE

PRINTED: 07/27/2018 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.				
		00818	B. WING		06/0	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	ICIS HOME		RANCIS DR			
T			NRIDGE, MN		ON	(УБ)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to elements of the following correction that you and identify the date Minnesota Department the State Licensing federal software. Tax	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 6/8/18, surveyors of this visited the above provider and ation orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed ent of Health is documenting. Correction Orders using ag numbers have been ota state statutes/rules for				
	column entitled "ID statute/rule out of constitute out out of constitute out of constitute out of constitute out of cons	RD THE HEADING OF THE				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LEIED
		00818	B. WING		06/0	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	NCIS HOME	2400 ST F	RANCIS DR	IVE		
OTTICAL	TOIOTIOME	BRECKE	NRIDGE, MN	56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 540	MN Rule 4658.0400 Resident Assessme	O Subp. 1 & 2 Comprehensive ent	2 540			7/18/18
	conduct a compreh resident's needs, w capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive resused to develop, recomprehensive plat 4658.0405. Subp. 2. Informatic comprehensive resinclude at least the A. medically demedical history; B. medical state C. physical and D. sensory and E. nutritional state F. special treat	ion; ential; n potential; tus; <i>r</i> ; and				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 3 of 40

PRINTED: 07/27/2018 FORM APPROVED

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NOWIDER. A. BUILDING:	
00818 B. WING 06/08/	/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ST FRANCIS HOME 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history and preferences for 1 of 4 residents (R1) reviewed for nutrition. Findings include: R1's significant change in status assessment Minimum Data Set (MDS) dated 5/16/18, identified R1 had diagnoses which included; dementia, Diabetes Mellitus, anxiety, depression, psychotic disorder and glaucoma. R1's MDS identified R1 had moderately impaired cognition and required extensive assistance from staff for all activities of daily living (ADLs) which included eating. Further, the MDS identified a weight of 98 pounds, a therapeutic diet and a weight loss of 5%, or more in the last month or loss of 10% or more in the last 6 months. R1's significant change in status Care Area Assessment (CAA) dated 5/29/18, identified for Nutritional Status CAA, the care area was an actual problem for R1, however the CAA did not explain the nature of the problem, it indicated R 1 had a significant change conference on 5/24/18, and to see chart note from the conference. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included; functional problems that affect ability to eat, cognitive, mental status and behavioral problems that could interfere with eating, communication problems, other diseases and conditions that could interfere with eating, communication problems that could interfere with eating.	

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 4 of 40

Minnesota Department of Health

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0	8/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANC	SIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
# # # # # # # # # # # # # # # # # # #	additional informatic problems, but each were blank. Under the Findings, the instruct Indicators & Support Conclusions. Docur Description of the Pontributing Factors Care Area" howeve was left blank. The analysis of the afore checkmarks, which status. The CAA fur considerations that status from resident and/or representative considerations. Review of facility properties of the considerations was Nutritional Status from the consideration was Comment", with an conference was held from the conference was held from the conference was held from the conference chart not conf	ge 4 a where staff could add on/analysis of the identified of the six comment areas the heading Analysis of ctions indicated "Review rting Documentation & Drawment the Following: Problem, Causes and s, Risk Factors Related to the r, the comment section for this CAA lacked a comprehensive ementioned pre-populated impacted R1's nutritional ther lacked any other could affect R1's nutritional tobservation and resident ve input for care planning Provided Resident CAA Audit /25/18, indicated the CAA type as "Current Eating Pattern answer of "Significant Change as "Current Eating Pattern answer of "No". The as "Current Eating Pattern	2 540			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER	2400 ST F	RANCIS DR			
			NRIDGE, MN		ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 5	2 540			
	no further weight lo further documentation for continued weight considerations or in prevent further weight on 6/8/18, at 11:25 (DS)-A confirmed so Status CAA dated so usual practice was and answer the que chart note. DS-A stated so CAA. DS-A stated so	nent) twice daily, and to have ss. The note lacked any ion of analysis of the reasons at loss and lacked further aterventions to attempt to ght loss. a.m. dietary supervisor he completed R1's Nutritional 5/29/18. DS-A indicated her to input information in the CAA estions, then would complete a lated the chart note was the she felt R1's Nutritional Status hensive analysis of R1's				
	(DON) stated she w	a.m. director of nursing vould expect R1's Nutritional comprehensive assessment trition needs.				
	The director of nurs review/revise facility then perform rando resident is compreh	THOD OF CORRECTION: sing (DON) or designee could y policies, educate staff and m audits to ensure each nensively assessed using the ent Instrument (RAI) process.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			7/18/18
	receive nursing car	general. A resident must e and treatment, personal and supervision based on				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 6 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER	2400 ST F	DRESS, CITY, S RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility fa safe use of a mech	ent is not met as evidenced on, interview and document ailed to accurately assess the anical lift for 2 of 2 residents d who experienced falls from		Corrected		
	identified R53 had sand had diagnosis was demential and stage MDS revealed R53 temporal orientation required extensive afor activities of daily transfers, bed mobil wheelchair. R53's admission Cadated 4/30/18, identicognitive impairment assistance from factors.	inimum Data Set dated, severe cognitive impairment which included malnutrition, e four (4) decubitus ulcer. The had difficulty with recall and n. The MDS revealed R53 assistance of two facility staff v living (ADL's,) including lity and locomotion with a are Area Assessment (CAA) tified R53 had severe nt and required physical cility staff for ADL's. The CAA significant malnutrition.				

Minnesota Department of Health STATE FORM

E FORM 6899 4WN411 If continuation sheet 7 of 40

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
OT TICAL	TOIO TIONIL	BRECKE	NRIDGE, MN	56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	R53's fall risk assessidentified R53 was a included the following periods of altered pure surroundings, restlevision, mobility, bala health conditions. R53's care plan revice cognitive impairment required assistance transfer belt, pivot of R53's fall incident reresults and mechanical liming wheelchair to bed. R53 had let go of the through the sling and R53's incident repointervention had beto transfer with 2 as	essment dated, 4/29/18, at high risk for falls due ng indicators; easily distracted, erception or awareness of essness, impaired cognition, ance, age, medications and ised 6/4/18, revealed R53 had nt, was at risk for falls and with transfers using a				
	revealed R53's fall	was an unanticipated move falls with the use of the FBL				
	wheelchair in front of kitchen area of the her breakfast and a	a.m. R53 was seated in a of the low counter in the neighborhood unit. R53 ate sked staff where her e she held a banana in her				
	wheelchair while nu wheeled R53 to her restorative nursing	a.m. R53 was seated in her assistant (NA)-G room. At that time facility assistant (RNA)-A entered at with transfer. NA-G donned				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 8 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER NCIS HOME	2400 ST F	DRESS, CITY, S FRANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	a transfer belt acros a pivot disk (assistive residents to pivot the on the floor in front placed her foot on the floor. R53 to stand, while her foot. R53 was a disk, turned and sacued by RNA-A. On 6/6/18, at 7:06 at (LPN)-C stated R53 transfers with two fallen during a mechanical lift. LPN the handle bars of the sling and onto her befollowing R53's fall used the FBL until Filter transfers. On 6/7/18, at 2:46 per fall incident on 5/16 director of nursing (officer/educator (S0 had fallen while she using a sit to stand let go of the handle that was the cause confirmed R53 had (used for average separated of sit to stand not offer sizes of sit however, she indicated sized slings. The Didiagnosis of malnut sized woman. The literature is a sit of the property	ge 8 ss R53's torso, RNA-A placed we device used to assist ansfer with assist and ease,) of R53's wheelchair. NA-G he pivot disk and assisted RNA-A cued R53 to turn with able to pivot with the use of the ton the edge of the bed when a.m. licensed practical nurse are required assistance with acility staff and a pivot disk. and fallen once since her onths ago. She stated R53 transfer with a sit to stand N-C stated R53 had let go of he lift and had slid through the outlocks. LPN-C stated from the sit to stand lift, staff R53 was able to assist with as was assisted to transfer lift. The DON confirmed R53 was assisted to transfer and felt of R53's fall. The DON been using a universal sling, sized adults) and indicated the diffs used by the facility did nall, medium or large. ated the facility's FBL's had ON confirmed R53 had a crition and felt she was a small DON confirmed R53's medical increhensive assessment of	2 830			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 9 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ST FRANCIS	S HOME		RANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Results factoring states of the states of th	nich would have in ctors, a root caus is sessment and fall is would expect the principal and fall in order sident during a tracility did not have sidents using the and lift were the ath a small stature 53's medical reconnether the universe propriate size for a 6/7/18, at 2:47 peen unaware of Rist. The SO-A stated is used a universate sling was to be as raised in the ainsure residents do not indicated she for exessarily be appreciated she had spole esent at the time dicated the sling unit of the side had been raised at then let go of the dicated she had been raised at through the sling used in 6/8/18, at 9:38 and inversal sling used in 6/8/18, at 9:38 and inversal sling used it did not fit R53. Note that the sling used it did not fit R53.	sit to stand lift on 5/16/18, included potential causative e analysis, post fall il risk assessment. She stated he slings to be tightened for the sling to secure the ansfer. The DON stated the a formal system for ensuring universal slings for the sit to ppropriate size for residents. Further the DON confirmed red lacked documentation had sling had been an R53. b.m. the SO-A stated she had the slings for the sit to stand ally sized sling and indicated tightened while the resident in order to maintain safety to be not slide through the sling. The latest through the sling had been an an another stature. b.m. registered nurse (RN)-A ken with the NA which was of the fall and she had used on R53 was a universal and tightened 2-3 times while d in the air. RN-A stated R53 he handles of the lift and had	2 830			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 10 of 40

Minnesota Department of Health

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00818	B. WING		06/0	8/2018
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST FRANCI	S HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
Stream O Co Co footh district m Co Si Si Stream Co W ream Co Stream Co W ream Co Stream Co Strea	esidents were to be appropriate sling. On 6/8/18, at 11:11 coordinator (RNCC) or assessing residente resident's ability irection, weight and tated she felt the unay not have fit her contributed to her factoributed her from her between the sling and lifted her from her between the sling tightened. On 6/8/18, at 11:45 was conducted with the presentative from cool) Health System than a lift utilized by accility used a universal sling. He seponsibility to enseppropriate fit for retated the sling straine resident was liftened sling. He stated	d various sized slings and e measured for the a.m. registered nurse clinical place and process ents transfer needs included to bear weight, follow doverall body frame. RNCC-A iniversal sling used for R53 means small frame and could have all from the sit to stand lift on a.m. LPN-D stated she had by R53 had fallen on 5/16/18. On duty had tightened the cross R53's chest while she had be despite the sling straps a.m. a telephone interview a customer service SMT (Sunrise Machine and the facility.) He indicated the cross ling for the sit to stand able to identify weight or actions for use with the stated it was the facility's sure the sling was an esidents. The representative p was to be tightened while ed to prevent sliding through he felt if a resident slid al sling after it was tightened,	2 830			

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	o. oo.u.zoo		A. BUILDING:				
		00818	B. WING		06/0	8/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ST FRAN	ICIS HOME		FRANCIS DR NRIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Volaro PA600/PA60 applying the sling p important part of the patient safety. The tighten the straps of was in the lift to kee A facility policy titled 5/18/18, identified it identify residents at interventions to predict A facility policy for usings was requested. R56's quarterly MD R56 was cognitively which included ane and hemiplegia (on identified R56 had limpairment and red two staff for ADL's it transfers. The MDS since the last quarter R56's CAA's dated required assistance lift for transfers and assist R56 when should staff were not famili indicated R56 had in R56's fall risk assesshe was at risk for the R56's care plan revenue.	ed operator manual for the 10S sit to stand lift, identified roperly was the most e lifting experience to ensure manual instructed staff to f the sling while the patient ep the sling snug. d, Fall Prevention, revised the was the facility's purpose to the risk for falls and to initiate event falls. Use of mechanical lifts and ed and not provided. S dated 5/11/18, identified wy intact and had diagnoses mia, congestive heart failure e sided paralysis.) The MDS oblateral upper extremity puried extensive assistance of including bed mobility and is identified R56 had no falls erly assessment. 9/19/17, identified R56 errom staff and a sit to stand indicated two staff should he was not feeling well or if the iar with her. The CAA no recent falls.	2 830				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 12 of 40

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST FRAM	NCIS HOME		RANCIS DR IRIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 830	lift for transfers. R56's incident deta revealed R56 had be stand lift and one fabed to the bathroom the NA turned the libathroom the lift tip lowered to the floor identified the wheel report revealed the manager had immeservice and Biomed. The report revealed transfer with two stareport did not identified the aforementioned serial number A870 had a broken bolt of wheel. On 6/4/18, at 1:57 ga while back from a had broken and the since then, she had with transfers with the follow up interview stated she could not sit to stand lift were tipped over. On 6/6/18, at 7:19 a transfer from the to and NA-D. While NR56 from the toilet,	ge 12 ills report dated 11/217, been transferred with a sit to acility staff assistance from her in. The report revealed when fit to maneuver it into the ped to the left and R56 was incident report to the lift had broken off. The facility's maintenance ediately removed the lift from it had taken the lift for service. If R56 was to be assisted to aff and a sit to stand lift. The fry whether the legs to the lift closed at the time of the fall. If dated 11/2/17, revealed the had used to transfer R56 in fall, was lift model PA600, in the left front castor of the lift. She indicated the wheel is lift. She indicated the wheel is lift tipped over. R56 stated to have two staff assist her he sit to stand lift. During a in 6/7/18, at 8:58 a.m. R56 it recall whether the legs of the opened at the time the lift had a.m. R56 was assisted to illet to her wheelchair by NA-FA-D used the lift controls to lift NA-F tightened the straps of a pulled the left away from the	2 830				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 13 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/	08/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
ST FRAM	NCIS HOME		FRANCIS DRI			
	T		NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	position, NA-D man to R56's wheelchair On 6/6/18, at 9:37 a assistance with trar a sit to stand lift. NA R56 when the lift tip had been transferring bathroom and had to extended in order for	a.m. NA-H stated R56 required asfers with two facility staff and A-H stated she had been with aped over and indicated she ag R56 from her recliner to the to have both of the legs or the lift to be moved close to stated she had raised R56 into				
	On 6/6/18, at 2:28 p Operation Manager notified when the si staff transferred R5 and secured the ca understand how the	e lift tipped to the left side. o.m. the facility Plant (POM)-A stated he had been t to stand lift had tipped while 6. He stated he had replaced ster and indicated he did not e wheel bolt had broken off.				
	not have been in the too much pressure stated the legs to the	e felt the legs to the lift could e open position and had put when the lift was turned. He he lift were required to be ng the lift to prevent tipping.				
	incident report date the director of nursi confirmed R56 had sit to stand lift. She report lacked a thor comprehensive ass 11/2/17. The DON didentify whether the opened during the r lift, and confirmed to component in identify	o.m. R56's medical record and d 11/2/17, were reviewed with ng (DON). The DON fallen during a transfer with a confirmed R56's incident ough analysis and essment of R56's fall on confirmed the report did not legs of the lift had been maneuvering of the sit to stand he information would be a key ifying potential root cause of pping over. She confirmed				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 14 of 40

Minnesota Department of Health

MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE PREPIX TRANCIS HOME 2400 ST FRANCIS DRIVE 2400 ST FRANCIS DRIVE RECULATORY OR LISC IDENTIFYING INFORMATION) PREPIX TAG COntinued From page 14 she had not spoken with maintenance to discuss any other potential factors which may have caused the lift to tip and/or the wheel castor bolt to break. The DON Stated she was not aware whether all of the other lifts in the facility had preventative maintenance completed following the incident with the sit to stand lift used with R56. On 6/8/18, at 10:32 a.m. the facility biomedical manger stated the facility had a maintenance every two years. The Biomed manager indicated to complete preventative maintenance every two years. The Biomed manager indicated he had not been comfortable glongli two years between preventative checks on the lifts, therefore he completed them annually. Review of an undated operator manual for the Volaro PA600/PA600S sit to stand lift, identified the legs of the lift were used for stabilizing the lift when maneuvering a patient in the lift. The manual indicated the lift would tip over if the legs were not in the open position. A facility policy titled, Fall Prevention, revised 5/18/18, identified it was the facility's purpose to identify residents at risk for falls and to initiate interventions to prevent falls. A facility policy for use of mechanical lifts and slings was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures regarding mechanical lifts, educate staff, and conduct random audits to ensure proper usage. In addition, the director of maintenance could	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ST FRANCIS HOME CAPATION DEPLOY CAPATION CAPATION			00818	B. WING		06/0	8/2018
PARTICIS HOME SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEPTICIENCY MUST BE PRECEDED BY PLAN PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPTICIENCY MUST BE PRECEDED BY PLAN PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEPTICIENCY OF LSC DEBINIFING INFORMATION) PREFIX TAG	NAME OF I	PROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 14 she had not spoken with maintenance to discuss any other potential factors which may have caused the lift to tip and/or the wheel castor both to break. The DON stated she was not aware whether all of the other lifts in the facility had preventative maintenance completed following the incident with the sit to stand lift used with R56. On 6/8/18, at 10:32 a.m. the facility biomedical manger stated the facility had a maintenance program for mechanical lifts, which indicated to complete preventative maintenance every two years. The Biomed manager indicated he had not been comfortable going two years between preventative checks on the lifts, therefore he completed them annually. Review of an undated operator manual for the Volaro PA600/PA600 Sit to stand lift, identified the legs of the lift were used for stabilizing the lift when maneuvering a patient in the lift. The manual indicated the lift would tip over if the legs were not in the open position. A facility policy fitted, Fall Prevention, revised 5/18/18, identified it was the facility's purpose to identify residents at risk for falls and to initiate interventions to prevent falls. A facility policy for use of mechanical lifts and slings was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures regarding mechanical lifts, educate staff, and conduct random audits to ensure proper usage. In	ST FRAM	ICIS HOME					
she had not spoken with maintenance to discuss any other potential factors which may have caused the lift to tip and/or the wheel castor bolt to break. The DON stated she was not aware whether all of the other lifts in the facility had preventative maintenance completed following the incident with the sit to stand lift used with R56. On 6/8/18, at 10:32 a.m. the facility biomedical manger stated the facility had a maintenance program for mechanical lifts, which indicated to complete preventative maintenance every two years. The Biomed manager indicated he had not been comfortable going two years between preventative checks on the lifts, therefore he completed them annually. Review of an undated operator manual for the Volaro PA600/PA600S sit to stand lift, identified the legs of the lift were used for stabilizing the lift when maneuvering a patient in the lift. The manual indicated the lift would tip over if the legs were not in the open position. A facility policy titled, Fall Prevention, revised 5/18/18, identified it was the facility's purpose to identify residents at risk for falls and to initiate interventions to prevent falls. A facility policy for use of mechanical lifts and slings was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures regarding mechanical lifts, educate staff, and conduct random audits to ensure proper usage.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
review/revise policies on mechanical lift	2 830	she had not spoker any other potential caused the lift to tip to break. The DON whether all of the or preventative mainted the incident with the On 6/8/18, at 10:32 manger stated the foregram for mechal complete preventative checks completed them and Review of an undativolaro PA600/PA60 the legs of the lift with when maneuvering manual indicated the were not in the ope A facility policy titled 5/18/18, identified it identify residents at interventions to pre A facility policy for usings was requested SUGGESTED MET The director of nurse review/revise policiem echanical lifts, ed random audits to en addition, the director of and the cause of the legs of the lift with the complete them.	n with maintenance to discuss factors which may have and/or the wheel castor bolt stated she was not aware ther lifts in the facility had enance completed following e sit to stand lift used with R56. a.m. the facility biomedical facility had a maintenance nical lifts, which indicated to ive maintenance every two manager indicated he had not oing two years between son the lifts, therefore he nually. The doperator manual for the loss sit to stand lift, identified ere used for stabilizing the lift a patient in the lift. The le lift would tip over if the legs in position. The facility's purpose to the risk for falls and to initiate event falls. The OF CORRECTION: The of mechanical lifts and end and not provided. THOD OF CORRECTION: The facility or designee, could est and procedures regarding ucate staff, and conduct insure proper usage. In or of maintenance could	2 830			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 15 of 40

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONST			(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/0	8/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	instructions were be	sure the manufacturer eing followed, set up a routine and perform audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			7/18/18
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	by: Based on observatireview the facility far pressure relieving in	ent is not met as evidenced on, interview and document illed to consistently implement interventions for 1 of 1 resident lek for pressure ulcers.		Corrected		
	Findings include:					
	R7's admission Min	imum Data Set (MDS) dated				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 16 of 40

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST FRAM	ICIS HOME		RANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	cognition and diagnal Alzheimer's diseased MDS identified R7 of for all activities of durther, R7's MDS the development of a turning and reposed R7's quarterly MDS had severely impair dependent on staff development of preasuring reposition R7's admission Cardated 10/20/17, revidevelopment of preasure for a functional limitation incontinence, cognic Alzheimer's diseased turning schedule. Route intact with exception foot under the pinky prevent skin breaked protector boots at a reposition every 2 to R7's care plan, reviat risk for impaired decreased mobility/self. R7's care plan which included blue times, and a photo correct placement of turn and reposition On 6/6/18, at 7:46 at 12.50 process.	7.7 had severely impaired loses which included; e, dementia and anemia. The was totally dependent on staff aily living (ADLs), did not walk. identified R7 was at risk for pressure ulcers, and was on itioning program. 6, dated 3/9/18, identified R7 red cognition, was totally for ADLs, remained at risk for essure ulcers and was not on ing program. 7 e Area Assessment (CAA) realed R7 had risk factors for essure ulcers of immobility with on in range of motion, tive loss with a diagnosis of e and required a regular (7's CAA listed her skin was no fa dry scab on her right of town R7 was to wear blue heel all times, and turn and to 3 hours. Sed 4/3/18, identified R7 was skin integrity related to funable to turn and reposition listed various interventions a heel protector boots on at all was posted in her room with of feet in chair when up, and	2 900			
		n the room. R7 had blue heel				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 17 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			D WING				
		00818	B. WING		06/	08/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	1010 11011	2400 ST I	FRANCIS DRI	VE			
ST FRAM	NCIS HOME	BRECKE	NRIDGE, MN	56520			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE	
2 900	Continued From pa	ge 17	2 900				
	hoots on both feet	however, R7's boots were not					
	1	and her heels did not rest in					
		ots. Both heels rested directly					
		protectors. NA-F and NAG-					
		a Broda chair and her blue					
		but not secured with Velcro					
	•	els did not rest in the holes of					
	the boots. At 8:18 a	.m. R7 remained seated in					
	her Broda chair, wit	h both heel protectors					
	present, but both heels not resting in the holes of						
		s heels rested directly on inside					
		rs. At 8:34 a.m. R7 remained					
		chair, with both heels resting					
		ling of the heel protectors.					
		ext to R7 assisting her to eat					
		dining room. At 9:12 a.m. R7					
		her Broda chair, with her rest directly on the inside of					
		F and NA-G pushed her in the					
		room and assisted R7 to					
		-G moved the blue heel					
		wheelchair and placed them					
		e heels in the heel cut outs					
		d a pillow under her right side					
	to reposition her off						
	·						
		us observations were					
		5 p.m. to 2:25 p.m. At 1:25					
		G were present with R7 in her					
		her to transfer from her Broda					
		the blue heel protectors in					
	•	pard of R7's wheelchair. NA-F					
		ed to assist R7 with personal					
	•	her with a pillow behind her					
		with her heels resting directly					
		's blue heel protectors were otboard of the Broda chair and					
		ced under R7's feet or lower					
		censed practical nurse (LPN)-					
		m and NA-F and NA-G exited					

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00818	B. WING		06/	08/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
ST FRANCIS HOME		FRANCIS DRIV NRIDGE, MN				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
R7's heels rested of bed. LPN-C exited blue heel protector heels. R7's blue heels. R7's feet and walked past R7's room. R7's heels room. NA-Fown, was very rigin cares. She indicate heel boots at all time every 2 hours. At 2:15 p.m. NA-Gor all activities of origid. NA-Gostated every two hours are blue heel boots at all time heel boots at all time every 2 hours. At 2:21 p.m. R7 room. R7	C assessed R7's ears while directly on the mattress of the the room without placing the boots or pillows under R7's eel protectors remained in the pillows was present under or heels. At 1:52 p.m. LPN-C oom, but did not enter R7's emained in the same position, tress of the bed. At 1:59 p.m. briefly entered R7's room and aff entered her room. I stated R7 did not move on her d and was total assistant with ed R7 was to wear the blue nes and was to be repositioned stated R7 required total cares daily living due to being too R7 was to be repositioned and indicated R7 was to wear the all times. I mained in the same position, sting directly on the mattress of as notified of R7's heels resting					

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 19 of 40

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/08/2018	
NAME OF PF	ROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	0/2010
ST FRANC	CIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	the observation. R7 and left heel was so indented when LPN there were no open On 6/6/18 at 2:32 p (RNCC)-A confirme ulcer development of decreased mobility She stated she wou floated off the mattr protectors at all time mattress because of ulcer development On 6/8/18 at 12:00 (DON) confirmed F ulcers due to her im move herself. She s to follow R7's care p prevention. A policy for pressure requested, but not p SUGGESTED MET The director of nurs all residents at risk they are receiving the treatment/services of from developing an pressure ulcers. The designee, could cor delivery of care; to o services are implen pressure ulcer devel	ed with LPN-C who confirmed "s both heels had dry skin, oft, mushy, and readily I-C palpated the area although areas noted. .m. RN clinical coordinator ed R7 was at risk for pressure due to her dementia, and did not move on her own. ald expect R7's heels to be ress or in the blue heel es, not resting directly on the of R7's potential for pressure mobility and her inability to stated she would expect staff plan for pressure ulcer e ulcer prevention was provided by facility. THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure the necessary to prevent pressure ulcers do promote healing of the director of nursing or neduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0)8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	ST FRANCIS HOME 2400 ST BRECKE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	-Nutritional Status Subpart. 2. Nutritio must ensure that a which supplies the o determined by the o assessment. Subst	O Subp. 2 Dietary Service nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			7/18/18
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and provide identified interventions for 1 of 1 residents (R1) reviewed with a significant weight loss. Findings include:			Corrected		
	R1's discharge retu Set (MDS) dated 4/diagnoses which ind disorder and diabet identified R1 require weight of 96 pounds (percent) or more in or more in last 6 more record documented pounds, which represent weight with a great the last month.	rn-anticipated Minimal Data 24/18, identified R1 had cluded anxiety, psychotic es mellitus. The MDS ed supervision with eating, and no weight loss of 5% on the last month or loss of 10% onths. However, R1's clinical a weight on 3/24/18, of 101.8 esented a significant change ater than 5% weight loss in nge in status assessment, identified R1 had moderately				

6899

Minnesota Department of Health

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ST FRANCIS HOME 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 965 Continued From page 21 assistance from staff for all activities of daily living (ADLs) which included eating. R1's MDS identified diagnoses which included: dementia, diabetes mellitus, anxiety, depression, psychotic disorder and glaucoma. R1's MDS further identified a weight of 98 pounds, a therapeutic 2 965 COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 965 (X5) (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 965			00818	B. WING		06/0	08/2018
ST FRANCIS HOME BRECKENRIDGE, MN 56520	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 965 Continued From page 21 assistance from staff for all activities of daily living (ADLs) which included eating. R1's MDS identified diagnoses which included: dementia, diabetes mellitus, anxiety, depression, psychotic disorder and glaucoma. R1's MDS further identified a weight of 98 pounds, a therapeutic	ST FRAM	ICIS HOME					
assistance from staff for all activities of daily living (ADLs) which included eating. R1's MDS identified diagnoses which included: dementia, diabetes mellitus, anxiety, depression, psychotic disorder and glaucoma. R1's MDS further identified a weight of 98 pounds, a therapeutic	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS) CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETE DATE
month or loss of 10% or more in the last 6 months. R1's nutritional status Care Area Assessment (CAA) dated 5/25/18, indicated a significant change care conference was held on 5/24/18, and to see chart note from the conference. Chart note dated 5/25/18, indicated R1's weight was 98 pounds, which was down 14 pounds since February 2018, R1 had a recent inpatient psychiatric stay and a regular diet. The note indicated R1's average meal food and fluid intake was poor. Staff were to continue to offer protein powder with each glass of milk, continue Juven (nutritional supplement) wice daily, and to have no further weight loss. The CAA lacked further analysis of R1's weight loss and considerations and interventions to attempt to prevent further weight loss. Review of R1's Dietary Risk Assessment dated 5/25/18, indicated a risk score of 13, which was considered high risk. R1's Resident Care Conferences form, identified as R1's significant change nutritional assessment, dated 5/24/18, indicated R1's weight was 98 pounds and weight last conference was 112 pounds, a decrease of 14 pounds. The form indicated R1 was on a regular diet and received nutritional supplement Pro-Pass (whey protein supplement powder provides 30 calories) with each glass of milk and Juven (therapeutic	2 965	assistance from state (ADLs) which include identified diagnoses diabetes mellitus, a disorder and glauce identified a weight of diet and a weight lo month or loss of 10 months. R1's nutritional state (CAA) dated 5/25/1 change care confer and to see chart no note dated 5/25/18, pounds, which was February 2018, R1 psychiatric stay and indicated R1's aver was poor. Staff wer powder with each gone (nutritional supplement form of the weight loss). Review of R1's Diet 5/25/18, indicated a considered high rist R1's Resident Care as R1's significant of assessment, dated was 98 pounds and 112 pounds, a decrindicated R1 was on nutritional supplement powder supplement supplement powder supplement	aff for all activities of daily living ded eating. R1's MDS is which included: dementia, inxiety, depression, psychotic oma. R1's MDS further of 98 pounds, a therapeutic oss of 5% or more in the last 10% or more in the last 10% or more in the last 6 indicated a significant rence was held on 5/24/18, one from the conference. Chart, indicated R1's weight was 98 down 14 pounds since had a recent inpatient did a regular diet. The note rage meal food and fluid intake re to continue to offer protein plass of milk, continue Juven the interest of the considerations of attempt to prevent further in attempt to prevent further that a regular diet is weight was 8 in attempt to prevent further in a triple of the conference of 13, which was in a triple of 14 pounds. The form of the regular diet and received ent Pro-Pass (whey protein in provides 30 calories) with	2 965			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 22 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/0	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	NCIS HOME		RANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	day. The form indicassistance at meals further indicated means included 3 breakfas and 4 supper meals at 0% or refused arper day. The noted possible reasons for considerations and prevent further weight was required to eat for cues and observing one staff as indicated cognitive deficit. R1 R1 left 25% or more meals and had poor intake as well as a resulting weight los and anxiety. R1's gmeals as evidence will not decline any record. R1's care printake and weights, meal replacements ordered, provide a environment at mean physical assist with nursing assistant where week, and R1 drammealtime/try to recorder protein powder R1's nursing assistant where week, and R1 drammealtime/try to recorder protein powder R1's nursing assistant where week, and R1 drammealtime/try to recorder protein powder R1's nursing assistant R1's	provides 95 calories) twice a lated R1 required set up is with coaching. The form leal intakes for R1 which least at 85%, 2 lunches at 25% is at 50% with all other meals and fluids at 755 milliliters (ML) lacked further analysis of lacked further analysis of lacked further to attempt to	2 965			

6899

Minnesota Department of Health

winnesc	Minnesota Department of Health					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00818	B. WING		06/0	8/2018
					1 00/0	0,2010
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR			
		BRECKEN	IRIDGE, MN	56520		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	TNATE	DAIL
				·		
2 965	Continued From pa	ge 23	2 965			
	On 6/6/18, at 11:42	a.m. R1 was assisted by staff				
		om table in the assistance				
		lace setting included a glass				
		ter, a plate with pork roast,				
		corn and sweet potato. NA-B				
		the table from R1 assisting				
		to eat. R1 was not eating, but				
		full dining room. At 11:49 a.m.				
		ne table to the left of R1 and				
		sident to eat. R1 was picking				
		oork with her left hand and				
		along with small sips of water.				
		as observed to take small				
		all bite of corn and small sip of				
		vould pick up a piece of pork,				
		and place it back on her plate				
		to eat. At 12:13 p.m. R1				
		d up from her chair, reached				
		walked back to her room. R1				
		s of corn and pork and drank				
		nces of milk and water. No				
		neal substitute, encouraged				
		ed R1 with her meal during the				
	entire observation.	od i (i wiai nei medi ddinig the				
	Critico obcorvation.					
	On 6/7/18, at 8:36 a	a.m. R1 walked down the hall				
		her walker and sat at a table				
		ning room. At 8:39 a.m. R1				
		the table looking at other				
		m. At 8:45 a.m. staff placed a				
		ro-pass mixed into it in front of				
	•	8:47 a.m. R1 had not				
		drink of milk. AA-L went to				
	•	dished up R1's breakfast				
		a small bowl of applesauce				
		ellied toast. activities assistant				
		t to R1, cut up the toast and				
		te of toast. R1 would not open				
	ner mouth. AA-L pia	aced a straw in the glass of				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 24 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMPI	
	00818	B. WING		06/0	8/2018
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS HOME		RANCIS DR			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
her milk, R1 would proceeded to offer a bite of toast, with take bites of the intimes to get R1 to success and gave a.m. AA-L transfer brought her back sips of milk and to AA-L did not offer alternatives during. On 6/7/18, at 11:2 back in bed with expectation of the same eating the lunch in walked by R1's roof ood items to a realing the lunch in walked by R1's room, but did remained lying in had entered her in entered R1's room recliner, sat next a glass of milk and on 6/7/18, at 2:17 through the lunch hard to get R1 to would sit, she wo stated R1 returnes stay in May and gothan before. She glasses of milk. On 6/7/18, at 2:27 very weak and very weak	ed to get R1 to take a drink of d not take a drink. AA-L r a spoonful of applesauce, and h R1 refusing to consistently tems. AA-L tried multiple more take a bite of the toast without the her another sip of milk. At 9:07 rred R1 to a wheelchair and to her room. R1 had consumed to her room. R1 had consumed to small bites of applesauce. any other menu items or go the breakfast meal. 12 a.m. R1 was lying on her eyes closed. At 11:47 a.m. R1 ne, as other residents were neal in the dining room. NA-A om as she delivered a tray of sident in the hall across from d not stop. At 12:14 p.m. R1 bed on her back and no staff froom. At 12:40 p.m. LPN-A n, assisted her to transfer to her to R1 and assisted her to drink	2 965			

Minnesota Department of Health

stated R1 had to be cued to eat and drink at

STATE FORM 6899 4WN411 If continuation sheet 25 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/0	08/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST FRAM	ST FRANCIS HOME 2400 ST BRECKE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	meals, got up from meals and wandere the nurse must hav lunch, otherwise sh dining room. On 6/up interview, NA-A then no we don't wa what the nurses told. On 6/7/18, at 2:32 pinpatient psychiatric when she came bad different person. The some medications as she wanders a lot a NA-D stated if staff eat, then R1 would almost all of R1's for all staff knew they cand focus long enorstaff were to offer Found then could chan 6/8/18, at 9:12 a.m. NA-D stated she have regarding nutritional restorative nursing manager including the continuation of 6/7/18, at 2:47 pc (LPN)-A stated R1's R1 would only take stated R1 loved mil milk and give her of and with meals. LP Juven twice a day. tried sitting R1 facing one item of food at from the table and confirmed no staff at	dining room chairs during ed between units. NA-A stated e directed not to get R1 for e would have been in the 8/18, at 9:00 a.m. in a follow stated, "if [R1] is sleeping, ake her up, at least that is	2 965			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 26 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/	08/2018
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 965	was currently at 93. to R1's psychiatric haggressive and wouthe facility and now would still eat about On 6/7/18, at 2:57 pa trained medication dining room every restated she tried to gmorning and stated other menu items a sips of milk or refus	5 pounds. LPN-A stated prior nospitalization she was alld stand near the exit door to R1 was more dosile, but the same amount. o.m. AA-L stated she was also naide and assisted in the morning she worked. She get R1 to eat breakfast that she had not offered R1 any fter the bites of apple sauce, all of toast. ght record from 12/1/17, to design the same amount in the morning she worked in the morning she worked. She get R1 to eat breakfast that she had not offered R1 any fter the bites of apple sauce, all of toast. ght record from 12/1/17, to design the same amount in the same amount in the same amount in the same amount.	2 965	BEI IGIENCT)		
	-5/18/18, 97.5 poun	ds				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 27 of 40

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	ICIS HOME		RANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 27	2 965			
	-5/25/18, 92.5 poun	ds				
	-6/2/18, 93.5 pound	s				
	Review of R1's meal consumption from 3/1/18, to 6/4/18, revealed:					
	-March 1-31, 2018, R1 consumed:					
	100% of the meal 6 times 75% of the meal 3 times 50% of the meal 1 time 25% of the meal 23 times 0% of the meal 29 times					
	Refused the meal 3 -April 1-24, 2018, R					
	100% of the meal 2 75% of the meal 1 t 50% of the meal 0 t 25% of the meal 15 0% of the meal 26 t Refused the meal 2	times ime imes times imes				
	-May 9-31, 2018, R	1 consumed:				
	100% of the meal 4 75% of the meal 3 t 50% of the meal 8 t 25% of the meal 18 t Refused the meal 2 -June 1-4, 2018, R ² 100% of the meal 0 75% of the meal 0	times times times times times times to times tonsumed:				

Minnesota Department of Health STATE FORM

50% of the meal 1 time

FORM 6899 4WN411 If continuation sheet 28 of 40

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.0	0.2010
ST FRANCIS HOME		RANCIS DR NRIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 28	2 965			
	25% of the meal 2 times 0% of the meal 1 time Refused the meal 8 times					
	Review of R1's Medication Administration Record (MAR) from 3/1/18, to 6/4/18, indicated R1 started ProPass on 3/23/18, and Juven on 5/10/18, which R1 regularly accepted.					
	Review of R1's progress notes from 5/9/18, until 6/4/18 revealed:					
	-5/9/18, R1 was weak, looked tired and worn out. R1 had a regular diet and placed in the assist dining room due to not eating.					
	lunch, but not much	t want breakfast, ate some n. Order from dietary manager ven supplements twice a day.				
	-5/11/18, R1 refuse	d to eat.				
	-5/12/18, R1 slept p 101.4 pounds.	oast breakfast. Current weight				
	-5/14/18, ate fair for anything for breakfa	r lunch and refused to eat ast.				
	-5/17/18, R1 continu	ued to eat poorly.				
	appetite, but poor a Weight now 97.5 po one to one for eatin	R1's physician on varied verage of 25% at meals. bunds. R1 continued to need g and drinking and needs to ncouraged to eat and drink.				
	-5/24/18, R1 slept tl	hrough supper.				
	-6/2/18, R1 ate a litt in each milk and Ju	tle for breakfast, had Propass ven at 1000.				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 29 of 40

Minnesota Department of Health

00818 B. WING 06/08/2018	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			00818	B. WING		06/0	8/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		ST FRANCIS HOME 2400 ST			IVE		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
2 965 Continued From page 29 2 965 -6/5 /18, R1's weight was 93.5 pounds. Restorative aid and nursing are working on a less stimulated atmosphere for her to eat at meal times. On 6/7/18, at 3:11 p.m. director of nutrition services (DNS)-A stated she was a dietician, but acted more as a consultant for the facility. She stated she was not aware R1 had lost that much weight. DNS-A stated the dietary supervisor (DS)-A oversaw the dietary program at the facility and felt she would have tried interventions prior to getting DNS-A involved. On 6/7/18, at 3:14 p.m. DS-A stated R1 had an inpatient psychiatric stay and when she returned medications had been decreased and therapy started due to deconditioning while hospitalized. DS-A stated R1 gained 5 pounds while hospitalized, but had begun to lose weight again. She stated R1 was hard to redirect, agitated and wandered a lot. DS-A indicated R1 was not drinking milk like she used to and not even eating cookies as much as before. The facility had trialed other juice and milk type supplements as well as high calorie cereal and potatoes in the past without success, but stated these interventions had not been attempted for R1 since the recent significant change. DS-A indicated since R1 had returned from hospitalization, staff had placed R1 back in the assistance dining room, continued to use Propass in each milk, started Juven and just started working on implementing a restorative eating program to decrease estimulation during meals. She indicated R1 had no specific snacks set up during the day to increase caloric intake.		-6/5 /18, R1's weight Restorative aid and stimulated atmosphit times. On 6/7/18, at 3:11 pservices (DNS)-A sacted more as a costated she was not weight. DNS-A state (DS)-A oversaw the and felt she would getting DNS-A invoiced in the state of the state	nt was 93.5 pounds. I nursing are working on a less here for her to eat at meal o.m. director of nutrition tated she was a dietician, but insultant for the facility. She aware R1 had lost that much ed the dietary supervisor edietary program at the facility have tried interventions prior to lived. o.m. DS-A stated R1 had an estay and when she returned een decreased and therapy anditioning while hospitalized. Indeed 5 pounds while ad begun to lose weight again. Hard to redirect, agitated and received to and not even eating as before. The facility had and milk type supplements as cereal and potatoes in the ses, but stated these of been attempted for R1 prificant change. DS-A had returned from a final placed R1 back in the com, continued to use lik, started Juven and just implementing a restorative decrease stimulation during ed R1 had no specific snacks	2 965			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
	00818	B. WING		06/08/2018	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS HOME		RANCIS DR			
		IRIDGE, MN			
PREFIX (EACH DEFICIENCY I			(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETE DATE
2 965 Continued From pag	je 30	2 965			
On 6/7/18, at 3:33 p. coordinator (RNCC)-weight loss was first continued until an inphospitalization. While about 5 pounds, but losing weight again. non-stop movement and fluids on the run would not allow assis but at present would stated R1 would at ti her chair in the dining R1 first so they can fa restorative eating put that week to trail a logenvironment with staneeded. She stated made some medicat Juven and family broat the point that she RNCC-B stated R1 requiring and up to total indicated she would encourage and assist menu options at each if R1 was not eating. On 6/8/17, at 11:17 a interview, DNS-A stated in long standing probindicated she did not nutritional assessment help. DNS-A stated is nutrition assessment not asked to do so. Significant change in a sked to do so. Significant sked to do so. Significant change in a sked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a sked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment nutrition assessment not asked to do so. Significant change in a long standing probindicated she did not nutrition assessment nutrition assessment nutrition assessment nutrition assessment nutrition assessment nutrition assess	m. registered nurse clinical -B stated R1's significant noted around 3/9/18 and patient psychiatric hospitalized, R1 gained since back to the facility was RNCC-B indicated R1 was and staff were to offer food to her. RNCC-B stated R1 stance at times in the past, allow staff to assist her. She mes pop up and down from g room and staff should feed focus on the meal. She stated brogram had just been set up w stimulated meal aff cueing and assisting as R1's physician recently tion adjustments, added brught in Oreo's, but now was no longer liked Oreo's. required supervision and all assistance for eating. She have expected staff to cue, st R1 with intake, offer R1 all th meal and offer alternatives	2 900			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 31 of 40

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 965	Continued From pa	ge 31	2 965			
	interventions, including looking at more supplements and documented if they were successful or not.					
	stated R1's gradual March. R1 had a per not calm down. Nur R1's medications, becontinued to decline inpatient psychiatric 5/9/18. DON indicate better after her returned going up and intake R1 would not sit do feeding her on the corder supplements, nutritional status and she would have exprotified after a couploss. She stated she an assessment from assistance with interwould have expected assist R1 as needed items and alternative.	director of nursing (DON) weight loss was noted in eriod of high anxiety and could sing and psychiatry adjusted out R1's quality of life e. R1 was then sent to an c hospital and then returned on ted R1 was eating a little rn, but now her anxiety was e was going down. She stated wn to eat and staff should be go. DON expected dietary to add snacks, monitor R1's ad intake closely. DON stated bected the dietician to be ole weeks of identified weight e would also have expected in the dietician and to provide erventions. DON indicated she ed staff to cue, encourage and d during a meal, offer all menu res and stated it would be etry and wake R1 if she were neal.				
	A facility policy titled: Resident Nutrition Intervention, last revised on 5/2016, indicated residents at nutritional risk and/or with unresolved weight loss would have an individual care plan addressing it. A systematic approach to nutrition interventions would assure all potential problem areas are addressed before going to an oral nutritional supplement. The policy listed various steps to take to increase oral intake such as: 6. Try high calorie snacks and foods at meal times and between meals 10. Refer to registered					

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 32 of 40

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00818	B. WING		06/0	8/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
2 965	Continued From pa dietician if all other resident continued	options had been tried and the	2 965			
	The Dietician could regarding residents	HOD OF CORRECTION: review/revise facility policies at nutritional risk, educate udits to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			7/18/18
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review the facility fa surveillance for the ensure tracking and	ent is not met as evidenced on, interview and document iled to conduct ongoing infection control program to I trending of viral infections		Corrected		
	failed to report a su the facility. In additional Legionella prograspread of infection facility failed to ensicannula were stored potential contamination 1 of 1 resident (1)	cility. In addition, the facility spected influenza outbreak in on, the facility failed to ensure m was in place to prevent the in the facility. Further, the ure oxygen tubing and nasald in a manner to prevent the tion during the use of oxygen ent practice had the potential				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 33 of 40

Minnesota Department of Health

Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7110 1 2711	or correction.	BERTH 10/ WIGHT 116 MBERT	A. BUILDING:			
		00818	B. WING		06/0	8/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME	2400 ST F	RANCIS DR	IVE		
OTTICAL	IOIO IIOME	BRECKEN	NRIDGE, MN	56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 33	21375			
	to affect all 66 resid	lents currently residing in the				
	Findings include:					
	was conducted on director of nursing (provided copies of Charge Sheets from listed daily various in hospital returns addrequired follow up. follow up listed variediagnosis of pneum failure, increased stocoumadin(blood the or increase in anticochange in use of m form listed R9 had a productive cough a influenza A. and had 4/2/18. On 4/4/18, influenza and ND h respiratory symptom the facility had report to the department of					
	charge sheet forms resident viral infecticonfirmed the facilit for resident viral illn at the end of the mothe antibiotics used month, and did not viral illness. She staprogram was informed did not look for tren	e facility utilized the 24 hour to review informally any ons in the facility. The DON by did not have a tracking tool ess in the building. She stated onth she would run a report on in the facility in the previous track specific organisms, or ated the infection control hal, and confirmed the facility ds or patterns with viral illness stated the facility had				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 34 of 40

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/08/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	ST FRANCIS HOME 2400 ST BRECKE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	discussed antibiotic however, the policy still in draft form at and hospital has ini antibiotic stewardsh. Review of the facilit Prevention and Correvealed there wou infections among prinfections that occur facilitate recognition well as clusters and Review of the facility Management, revist facility would condure port the outbreak local authorities. Review of the Minn form titled Long Ter RSV Form, 2017-18 laboratory confirme along with other casunit. Legionella On 6/6/18, at 6:55 a pond was made ou entrance. The pond parking lot and had The fountain sprayeair. At 7:15 a.m. during courtyards were observed.	e stewardship in the facility, for antibiotic stewardship was present and both the nursing tiated education for staff on hip. Experimental program, revised 12/17, Id be ongoing monitoring for atients and documentation of a rand systems in place to not increases in infections as doutbreaks. Experimental program of titled Outbreak ed on 2/16, revealed the loct outbreak monitoring and to the appropriate state and esota Department of Health of Care Facility Influenza and 8, defined an outbreak as one dinfluenza positive case sees of respiratory illness in a same aliquent to the facility's a large fountain in the center. The ed water from it's base into the served. Each courtyard	21375			
		oproximate two-foot water				

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 35 of 40

winnesc	<u>ita Department of He</u>	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00818	B. WING		06/08/2018	
		00010			06/0	0/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2400 ST F	RANCIS DR	IVE		
ST FRAM	ICIS HOME		NRIDGE, MN			
	OUR MAA DV OTA				211	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
21275	Cantinuad Frame	ma 05	21375			
21375	Continued From pa	ge 35	21375			
	A review of the facil	lity's Legionella program was				
		8 at 12:40 p.m. with the plant				
		r (POM)-A present. POM-A				
		ent of their campus for water				
		ot been conducted. He stated				
		water management had not				
	been completed and was only in draft form at present. He stated he checked the water weekly for chlorine levels, and he felt if the chlorine levels					
		water was acceptable. The				
		he facilty had several water				
		irtyards of the facility that had				
		and not been assessed for				
	potential concerns	with Legionella. The POM-A				
		the draft policy for review at				
		er Management Policy, dated				
		old letters on all pages of the				
		draft policy listed examples				
		water quality in various areas				
		raft policy did not include				
		r areas in the facility for				
		not include directions for that				
	monitoring.	not morado directione for that				
	g .					
	Review of the form	titled Water Samples Free				
		/18 to 6/5/18, revealed a water				
		ested from a random room in				
		care and acute care center of				
	•	. However, the form lacked				
	documentation of any further testing, or monitoring or preventative measures done to					
		egionella to grow or spread.				
		g				
	Review of policy pr	ovided by the facility titled				
		onnaires Disease, dated 1/18,				
		nent program would identify				
		g where Legionella could grow				
		determine the control				
		olied, and implement				
	measures to be abl	onou, and implement				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 36 of 40 4WN411

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00818	B. WING		06/0	8/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS HOME		RANCIS DRI NRIDGE, MN			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
growth and spread various locations wheaters and public policy did not identification decorative water for control measures for fountains. R52's quarterly Min 5/8/18, revealed R5 cognition and had copulmonary heart disanxiety. The MDS a independent with an eeded supervision received oxygen the R52's current signed 5/23/18, revealed R5 two liters per nasal per day during ever change one time per night. R52's current electromagnet (EMAR) was review revealed R52 was of two liters per nasal day during evening. Review of R62's cur 5/17/18, indicated Finstability related to heart failure and costent placement. R52 was content placement.	ring of the areas to prevent the of Legionella. The policy listed thich included showers/sinks. water mains. However, the fy the multiple facility untains, and did not include or the decorative water simum Data Set (MDS) dated 52 had moderately impaired diagnoses which included sease, heart failure and also indicated R52 was ctivities of daily living (ADL's), no fone staff with transfers and erapy. Sed physician orders dated R52 had an order for oxygen at cannula at night, two times ning and night. Oxygen tubing er day every 14 days during Tonic medication record wed from 5/18 to 6/18, currently receiving oxygen at cannula at night two times per and night. The policy listed on R52 was at risk for cardiac on hypertension, congestive or onary artery disease with 52's care plan listed various included oxygen as needed	21375	DEI IGIENCI)		

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00818	B. WING		06/0	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS HOME		RANCIS DR NRIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	During observations was seated in her wher bed. A oxygen was located on the right recliner. The oxygen oxygen tubing was unit and the tubing observed curled up night stand next to -At 1:25 p.m. nursing the room, and step tubing and nasal caproceeded to put a waist, assisted R52 transferred R52 frowhile continuing to and nasal cannular of her night stand. It bed by herself while R52's closet for her coxygen, NA-A react up R52's oxygen tubing and applied tubing and applied tubing and applied tubing around her coxygen was running the plastic green ox with a black market -At 2:12 p.m. R52 cowith her oxygen tubit to both of her nostriliters per minute an connector was date -At 4:19 p.m. R52 cowith her oxygen tubits on the roxygen tubits of th	s on 6/4/18 at 1:24 p.m. R52 wheelchair in her room next to wall unit with bubbler was side of the wall above R52's n wall unit was running, the connected to the oxygen wall and nasal cannula were on the floor in front of R52's her bed. In g assistant (NA)-A entered ped directly on the oxygen annula with her shoes. NA-A transfer belt around R52's to a standing position and m her wheelchair to her bed walk on R52's oxygen tubing while it laid on the floor in front R52 proceeded to lay down in a NA-A got a pillow case out of pillow. In sked the NA-A about her hed down to the floor, picked bing and nasal cannula off the to R52. R52 took the oxygen the nasal cannula part of the ner nostrils and wrapped the ears independently. R52's got at two liters per minute and oxygen connector was dated 5/2	21375			

Minnesota Department of Health

STATE FORM 6899 4WN411 If continuation sheet 38 of 40

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00818	B. WING		06/0	8/2018
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS	ST FRANCIS HOME 2400 ST BRECKE					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
lite co Du wa an with the with the with co wa no R5 wa that lyir on Or (R wa ne inc sh pra EN state ca statut	uring observations as laying in bed read nasal cannula at the oxygen running e plastic green ox the a black marker on 6/5/18 at 2:41 p. Elized oxygen where of the oxygen where of the oxygen oxygen of the oxygen o	d the plastic green oxygen d 5/2 with a black marker. s on 6/5/18 at 8:51 a.m. R52 sting with her oxygen tubing applied to both of her nostrils at two liters per minute and ygen connector was dated 5/2. m. NA-A confirmed R52 n needed and at night. NA-A en tubing and nasal cannula or in R52's room and she had gen tubing or nasal cannula for n lying on the floor and dicated she was not aware d on the tubing while it was d stated "I should of got a new m. R52 confirmed she did get nes and would apply her nnula. R52 indicated she when she rests, at night and				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	8/2018
	PROVIDER OR SUPPLIER	2400 ST I	DRESS, CITY, S FRANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21375	confirmed R52 work expect staff to throw tubing away and to Review of the facilit Therapy revised on tubing and extension weeks or more ofter SUGGESTED MET The DON (Director review/revise facility contain all compone program, including illnesses in the facil stewardship progra assessment and pla pathogens. In addi could review/revise regarding oxygen to designee could edu to ensure the policie	.m. director of nursing (DON) e oxygen and she would the contaminated oxygen get a new one. y policy titled, Oxygen 3/13, indicated nasal cannulains will be changed every two	21375	DEFICIENCY		

6899