DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4WN4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00818

1. 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: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/27/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **80** (L18)
13.Total Certified Beds **80** (L17)

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 The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Gail Anderson, Unit Supervisor 08/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 08/01/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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

DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
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

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 4WN4

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(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
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/08/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Denise Erickson, HFE NE II 07/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/30/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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

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. 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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/4/18, through 6/8/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		7/18/18

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

Electronically Signed | 07/06/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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, 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. On 6/7/18, at 3:05 p.m. during a group interview with the licensed social worker (LSW) and	F 607	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 2 director of nursing (DON), the LSW and DON confirmed the current facility policy and both stated they were not aware of the 2 hour requirement of reporting allegations of abuse or events which caused serious bodily injury. The DON stated they felt the facility policy which directed any allegations were to reported immediately but no later than 24 hours met the requirements.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		7/18/18

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F 609	Continued From page 3 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential neglect were immediately reported, no later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury to the State Agency, and conduct a thorough investigation for 1 of 2 residents (R56) reviewed for potential neglect when a fall occurred during use of a mechanical lift. Findings include: R56's quarterly MDS dated 5/11/18, identified R56 was cognitively intact and had diagnoses which included anemia, congestive heart failure and hemiplegia (one sided paralysis). The MDS identified R56 had bilateral upper extremity impairment and required extensive assistance of two staff for ADL's including bed mobility and transfers. The MDS identified R56 had no falls since the last quarterly assessment. R56's CAA dated 9/19/17, identified R56 required assistance from staff and a sit to stand lift for transfers and indicated two staff should assist R56 when she was not feeling well or if the staff were not familiar with her. The CAA indicated R56 had no recent falls. R56's incident details report dated 11/2/17, revealed R56 had been transferred with a sit to stand lift and one facility staff assistance from her bed to the bathroom. The report revealed when the NA turned the lift to maneuver it into the bathroom the lift tipped to the left and R56 was	F 609	A Vulnerable Adult report will be made for all falls involving the use of a mechanical lift to assure all incidents are properly reported. The revision will be applied to all resident incidents involving falls while using the mechanical lifts. Verbal education on following the Vulnerable Adult procedures when there is a fall or near miss with the use of the mechanical lifts 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 education 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 to reflect that VA's will be submitted to the State agency and then an investigation will occur. Vulnerable Adult reporting will be monitored by Social Services and Nursing through the Daily Incident and Accident report and review of nurse notes to	

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F 609	Continued From page 4 lowered to the floor. R56's incident report identified the wheel to the lift had broken off. The report revealed the facility's maintenance manager had immediately removed the lift from service and biomed had taken the lift for service. The report revealed R56 was to be assisted to transfer with two staff and a sit to stand lift. The report did not identify whether the legs to the lift had been in the opened or closed position at the time of the fall. The report lacked further documentation of the possible causes for the equipment malfunction. On 6/7/18, at 2:15 p.m. R56's medical record and incident report dated 11/2/17, were reviewed with the DON. The DON confirmed R56 had fallen during a transfer with a sit to stand lift. She confirmed R56's incident report lacked a thorough analysis and comprehensive assessment of R56's fall on 11/2/17. The DON confirmed the report did not identify whether the legs of the lift had been opened during the maneuvering of the sit to stand lift, and confirmed the information would be a key component in identifying potential root cause of the sit to stand lift tipping over. She confirmed 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 6/7/18, at 2:30 p.m. the LSW-A stated she not reported R56's fall on 11/2/17, as she did not feel it met the criteria due to no injury and no intent of harm by the staff.	F 609	ensure all incidents are reported appropriately. Quality Assurance/Performance Improvement audits which are conducted by Social Services and charge nurse will be reported at QAPI meeting. Monitoring will continue until 4 consecutive months of compliance have been attained. Responsible: DON and Social Worker	

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F 609	Continued From page 5 On 6/7/18, at 3:30 p.m. the facility's policy for abuse prohibition and reporting was reviewed with the DON and LSW-A, both of which confirmed the policy lacked the two hour reporting for cases of reported and/or suspected abuse/neglect. 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. A facility policy titled: Appendix B-Long Term Care (Nursing Home) revised 1/18, revealed it was the facility's policy to complete an initial investigation of an incident and accident report to determine the need for a VA report to be submitted to the State agency.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		7/24/18

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F 636	Continued From page 6	F 636		

(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility

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F 636	Continued From page 7 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This 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 R1 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	F 636	R1 expired on 6-17-18. CAA's will be reviewed and updated at weekly IDT meetings. RN's, Dietician and AM Dietary Supervisor will be educated on thorough completion of CAA's. Verbal education on appropriate nutritional interventions relating to weight loss will be conducted at daily Safety Huddles for 1 week. Written education 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 education 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 for 4 weeks and then 1 chart weekly until the next QAPI meeting to assure that CAA's are completed. A performance improvement will will be completed and reviewed at next QAPI meeting. Monitoring will continue until 4 consecutive months of compliance have been attained. Responsible DON and Director of	

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F 636	Continued From page 8	F 636	Nutrition Services	

eating, communication problems, other diseases and conditions that could affect appetite or nutritional needs, medications and environmental factors. Each of the above pre-populated areas had a comment area where staff could add additional information/analysis of the identified problems, but each of the six comment areas were blank. Under the heading Analysis of Findings, the instructions indicated, "Review Indicators & Supporting Documentation & Draw Conclusions. Document the Following: Description of the Problem, Causes and Contributing Factors, Risk Factors Related to the Care Area" however, the comment section for this was left blank. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks, which impacted R1's nutritional status. The CAA further lacked any other considerations that could affect R1's nutritional status from resident observation and resident and/or representative input for care planning considerations.

Review of facility provided Resident CAA Audit Trail for R1 dated 5/25/18, indicated the CAA type was Nutritional Status. The Audit Trail had 3 CAA questions with answers. The first question was "Cardiac Drugs", with an answer of "No". The second question was "Current Eating Pattern Comment", with an answer of "Significant Change conference was held on 5/24/18. See chart note from the conference". The third question was "Care Planning Decision Comment", with the answer "Proceed to care plan. CAA, Care Plan, Risk Assessment, etc, completed/updated."

Review of R1's significant change care conference chart note dated 5/25/18, indicated R1's weight was 98 pounds, which was down 14

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F 636	Continued From page 9 pounds since February, 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) twice daily, and to have no further weight loss. The note lacked any further documentation of analysis of the reasons for continued weight loss and lacked further considerations or interventions to attempt to prevent further weight loss. On 6/8/18, at 11:25 a.m. dietary supervisor (DS)-A confirmed she completed R1's Nutritional Status CAA dated 5/29/18. DS-A indicated her usual practice was to input information in the CAA and answer the questions, then would complete a chart note. DS-A stated the chart note was the CAA. DS-A stated she felt R1's Nutritional Status CAA was a comprehensive analysis of R1's nutritional status. On 6/8/18, at 11:43 a.m. director of nursing (DON) stated she would expect R1's Nutritional Status CAA to be a comprehensive assessment of her individual nutrition needs.	F 636		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		7/18/18

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F 686	Continued From page 10 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement pressure relieving interventions for 1 of 1 resident (R7) reviewed at risk for pressure ulcers. Findings include: R7's admission Minimum Data Set (MDS) dated 10/2/17, identified R7 had severely impaired cognition and diagnoses which included: Alzheimer's disease, dementia and anemia. The MDS identified R7 was totally dependent on staff for all activities of daily living (ADLs), did not walk. Further, R7's MDS identified R7 was at risk for the development of pressure ulcers, and was on a turning and repositioning program. R7's quarterly MDS dated 3/9/18, identified R7 had severely impaired cognition, was totally dependent on staff for ADLs, remained at risk for development of pressure ulcers and was not on a turning repositioning program. R7's admission Care Area Assessment (CAA) dated 10/20/17, revealed R7 had risk factors for development of pressure ulcers of immobility with a functional limitation in range of motion, incontinence, cognitive loss with a diagnosis of Alzheimer's disease and required a regular turning schedule. R7's CAA listed her skin was intact with exception of a dry scab on her right foot under the pinky toe. The CAA directed to	F 686	Staff were educated via huddle board and huddles x 1 week that resident must have blue heel protector boots on always and correctly placed for pressure ulcer prevention. Staff educated on always following the care sheets which reflect residents plan of care. All residents will be reviewed for risk of pressure ulers. Any resident with noted skin breakdown at their next quarterly Braden assessment and tissue tolerance testing will have interventions put in place to improve the breakdown. Weekly audits will be completed on residents who have been identified with risk of skin breakdown to assure that proper interventions have been put in place to improve skin integrity. Weekly audits will be conducted on residents who wear blue heel protectors ensure they are being worn and worn correctly according to care plan. DON will complete audits for 4 weeks. Education on blue heel protector boots and following the care sheets for providing quality resident care will be conducted at daily Safety Huddles for 1 week. Written education will be posted on each neighborhood and staff are required to sign off that they have read and understood the changes. Additional	

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F 686	Continued From page 11 prevent skin breakdown R7 was to wear blue heel protector boots at all times, and turn and reposition every 2 to 3 hours. 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 protectors from her wheelchair and placed them on R7's feet with the heels in the heel cut outs	F 686	training will be conducted with all staff during the annual Skills Day training this month. PRN staff will receive education material via mail with a signature page that must be returned stating that they have read and understood the changes. Audits on skin breakdown and blue heel protectors are in place and worn correctly. A performance improvement plan will be implemented and reviewed at next QA meeting. Monitoring will continue until 4 consecutive months of compliance have been attained. Responsible: DON	

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F 686	Continued From page 12	F 686		

correctly and placed a pillow under her right side to reposition her off of her buttocks.

On 6/6/18 continuous observations were conducted from 1:25 p.m. to 2:25 p.m. At 1:25 p.m. NA-F and NA-G were present with R7 in her room and assisted her to transfer from her Broda chair to bed leaving the blue heel protectors in place on the foot board of R7's wheelchair. NA-F and NA-G proceeded to assist R7 with personal cares and position her with a pillow behind her back onto her side with her heels resting directly on the mattress. R7's blue heel protectors were observed on the footboard of the Broda chair and no pillows were placed under R7's feet or lower legs. At 1:35 p.m. licensed practical nurse (LPN)-C entered R7's room and NA-F and NA-G exited R7's room. LPN-C assessed R7's ears while R7's heels rested directly on the mattress of the bed. LPN-C exited the room without placing the blue heel protector boots or pillows under R7's heels. R7's blue heel protectors remained in the Broda chair and no pillows was present under or near R7's feet and heels. At 1:52 p.m. LPN-C walked past R7's room, but did not enter R7's room. R7's heels remained in the same position, directly on the mattress of the bed. At 1:59 p.m. laundry personnel briefly entered R7's room and exited. No other staff entered her room.

At 2:10 p.m. NA-F stated R7 did not move on her own, was very rigid and was total assistant with cares. She indicated R7 was to wear the blue heel boots at all times and was to be repositioned every 2 hours.

At 2:15 p.m. NA-G stated R7 required total cares for all activities of daily living due to being too rigid. NA-G stated R7 was to be repositioned

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every two hours and indicated R7 was to wear the blue heel boots at all times.

At 2:21 p.m. R7 remained in the same position, with both heels resting directly on the mattress of the bed. LPN-C was notified of R7's heels resting directly on the mattress at that time.

At 2:22 p.m. LPN-C stated R7 only utilized the blue heel protectors while in the chair, and was not aware if she wore the heel protectors at night. After review of R7's care plan, LPN-C stated R7 was to wear the blue heel protectors at all times. She indicated R7's left heel was softer than the right heel but did not have any open areas at present. She indicated R7's heels had been red in the past, and she would expect the heel protectors to be on at all times. At 2:25 p.m. R7's heels were observed with LPN-C who confirmed the observation. R7's both heels had dry skin, and left heel was soft, mushy, and readily indented when LPN-C palpated the area although there were no open areas noted.

On 6/6/18 at 2:32 p.m. RN clinical coordinator (RNCC)-A confirmed R7 was at risk for pressure ulcer development due to her dementia, decreased mobility and did not move on her own. She stated she would expect R7's heels to be floated off the mattress or in the blue heel protectors at all times, not resting directly on the mattress because of R7's potential for pressure ulcer development

On 6/8/18 at 12:00 p.m. the director of nursing (DON) confirmed R7 was at risk for pressure ulcers due to her immobility and her inability to move herself. She stated she would expect staff to follow R7's care plan for pressure ulcer

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	245265	A. BUILDING _____ B. WING _____	06/08/2018

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ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

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F 686	Continued From page 14 prevention. A policy for pressure ulcer prevention was requested, but not provided by facility.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess the safe use of a mechanical lift for 2 of 2 residents (R53, R56) reviewed who experienced falls from sit to stand lifts. Findings include: R53's admission Minimum Data Set dated, identified R53 had severe cognitive impairment and had diagnosis which included malnutrition, dementia and stage four (4) decubitus ulcer. The MDS revealed R53 had difficulty with recall and temporal orientation. The MDS revealed R53 required extensive assistance of two facility staff for activities of daily living (ADL's,) including transfers, bed mobility and locomotion with a wheelchair. R53's admission Care Area Assessment (CAA)	F 689	Resident who slid from the stand-up lift now transfers with a pivot disc and 2 staff. 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 will be educated on new upcoming sling sizes 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□s recommendations to assure that all lifts are in proper working order. All residents currently using the stand-up lift for transfers will be assessed by IDT at next meeting (7/3/18) ensuring they are appropriate to use the standup lift.	7/18/18

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F 689	Continued From page 15 dated 4/30/18, identified R53 had severe cognitive impairment and required physical assistance from facility staff for ADL's. The CAA indicated R53 had significant malnutrition. R53's fall risk assessment dated, 4/29/18, identified R53 was at high risk for falls due included the following indicators; easily distracted, periods of altered perception or awareness of surroundings, restlessness, impaired cognition, vision, mobility, balance, age, medications and health conditions. R53's care plan revised 6/4/18, revealed R53 had cognitive impairment, was at risk for falls and required assistance with transfers using a transfer belt, pivot disk and two assist. R53's fall incident report dated 5/16/18, revealed R53 had been assisted to transfer with a sit to stand mechanical lift (stand up lift, SUL) from a wheelchair to bed. The incident report revealed R53 had let go of the handles on the lift and slid through the sling and onto the floor of her room. R53's incident report revealed an immediate intervention had been implemented to assist R53 to transfer with 2 assist and a full body lift (FBL.) R53's fall incident report updated 5/22/18, revealed R53's fall was an unanticipated move and had no further falls with the use of the FBL with two assist. On 6/6/18, at 7:32 a.m. R53 was seated in a wheelchair in front of the low counter in the kitchen area of the neighborhood unit. R53 ate her breakfast and asked staff where her breakfast was, while she held a banana in her right hand.	F 689	Biomed completed routine maintenance on all lifts 6-20-18. IDT will review appropriateness of current lift being used for all residents with each MDS assessment. Facility will be purchasing new slings for the standup lifts that would be different sizes based on resident□s weight. Bio med will complete lift routine maintenance as directed according to manufacturer□s recommendations. Education on proper mechanical lift will be conducted at daily Safety Huddles for 1 week. Written education 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 education material via mail with a signature page that must be returned stating that they have read and understood the changes. Audits will be conducted weekly to assure that aides are using the appropriate sling size for stand up lifts. A performance improvement plan will be implemented and reviewed at next QA meeting. Monitoring will continue until 4 consecutive months of compliance have been demonstrated. Responsible: DON	

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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 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 fallen while she was assisted to transfer using a sit to stand lift. The DON stated 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, (used for average sized adults) and indicated the

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F 689	Continued From page 17	F 689		

brand of sit to stand lifts used by the facility did not offer sizes of small, medium or large. However, she indicated the facility's FBL's had sized slings. The DON confirmed R53 had a diagnosis of malnutrition and felt she was a small sized woman. The DON confirmed R53's medical record lacked a comprehensive assessment of R53's fall from the sit to stand lift on 5/16/18, which would have included potential causative factors, a root cause analysis, post fall assessment and fall risk assessment. She stated she would expect the slings to be tightened during a lift in order for the sling to secure the resident during a transfer. The DON stated the facility did not have a formal system for ensuring residents using the universal slings for the sit to stand lift were the appropriate size for residents with a small stature. Further, the DON confirmed R53's medical record lacked documentation whether the universal sling had been an appropriate size for R53.

On 6/7/18, at 2:47 p.m. the SO-A stated she had been unaware of R53's fall from the sit to stand lift. The SO-A stated the slings for the sit to stand lifts used a universally sized sling and indicated the sling was to be tightened while the resident was raised in the air in order to maintain safety to ensure residents do not slide through the sling. She indicated she felt a universal sling would not necessarily be appropriate for smaller stature residents.

On 6/7/18, at 3:19 p.m. registered nurse (RN)-A stated she had spoken with the NA which was present at the time of the fall and she had indicated the sling used on R53 was a universal sling which had been tightened 2-3 times while she had been raised in the air. RN-A stated R53

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F 689	Continued From page 18	F 689		

had then let go of the handles of the lift and had slid through the sling.

On 6/8/18, at 9:38 a.m. NA-G stated she felt the universal sling used with the facility's sit to stand lift did not fit R53. NA-G stated she felt R53 was very forgetful and would not be able to hold onto the lifts handles for long without verbal cues. She stated the FBL's had various sized slings and residents were to be measured for the appropriate sling.

On 6/8/18, at 11:11 a.m. registered nurse clinical coordinator (RNCC)-A stated her usual process for assessing residents transfer needs included the resident's ability to bear weight, follow direction, weight and overall body frame. RNCC-A stated she felt the universal sling used for R53 may not have fit her small frame and could have contributed to her fall from the sit to stand lift on 5/16/18.

On 6/8/18, at 11:16 a.m. LPN-D stated she had been on duty the day R53 had fallen on 5/16/18. She stated the NA on duty had tightened the straps of the sling across R53's chest while she had lifted her from her wheelchair to bed. She stated R53 had then let go of the lifts handles and slid through the sling despite the sling straps being tightened.

On 6/8/18, at 11:45 a.m. a telephone interview was conducted with a customer service representative from SMT (Sunrise Machine and Tool) Health Systems (manufacturer of the sit to stand lift utilized by the facility.) He indicated the facility used a universal sling for the sit to stand lift and he was not able to identify weight or measurement restrictions for use with the

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universal sling. He stated it was the facility's responsibility to ensure the sling was an appropriate fit for residents. The representative stated the sling strap was to be tightened while the resident was lifted to prevent sliding through the sling. He stated he felt if a resident slid through the universal sling after it was tightened, then the sling was not safe to use.

Review of an undated operator manual for the Volaro PA600/PA600S sit to stand lift, identified applying the sling properly was the most important part of the lifting experience to ensure patient safety. The manual instructed staff to tighten the straps of the sling while the patient was in the lift to keep the sling snug.

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.

R56's quarterly MDS dated 5/11/18, identified R56 was cognitively intact and had diagnoses which included anemia, congestive heart failure and hemiplegia (one sided paralysis.) The MDS identified R56 had bilateral upper extremity impairment and required extensive assistance of two staff for ADL's including bed mobility and transfers. The MDS identified R56 had no falls since the last quarterly assessment.

R56's CAA's dated 9/19/17, identified R56 required assistance from staff and a sit to stand lift for transfers and indicated two staff should

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assist R56 when she was not feeling well or if the staff were not familiar with her. The CAA indicated R56 had no recent falls.

R56's fall risk assessment dated 5/9/18, identified she was at risk for falls.

R56's care plan revised 5/17/18, identified R56 was at risk for falls and required extensive assistance of two facility staff and the sit to stand lift for transfers.

R56's incident details report dated 11/217, revealed R56 had been transferred with a sit to stand lift and one facility staff assistance from her bed to the bathroom. The report revealed when the NA turned the lift to maneuver it into the bathroom the lift tipped to the left and R56 was lowered to the floor. R56's incident report identified the wheel to the lift had broken off. The report revealed the facility's maintenance manager had immediately removed the lift from service and biomed had taken the lift for service. The report revealed R56 was to be assisted to transfer with two staff and a sit to stand lift. The report did not identify whether the legs to the lift had been open or closed at the time of the fall.

A facility work order dated 11/2/17, revealed the sit to stand lift staff had used to transfer R56 in the aforementioned fall, was lift model PA600, serial number A8700. The order revealed the lift had a broken bolt on the left front castor of the wheel.

On 6/4/18, at 1:57 p.m. R56 stated she had fallen a while back from a lift. She indicated the wheel had broken and the lift tipped over. R56 stated since then, she had to have two staff assist her

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F 689	Continued From page 21	F 689		

with transfers with the sit to stand lift. During a follow up interview on 6/7/18, at 8:58 a.m. R56 stated she could not recall whether the legs of the sit to stand lift were opened at the time the lift had tipped over.

On 6/6/18, at 7:19 a.m. R56 was assisted to transfer from the toilet to her wheelchair by NA-F and NA-D. While NA-D used the lift controls to lift R56 from the toilet, NA-F tightened the straps of the sling. NA-D then pulled the left away from the toilet, while both legs of the lift were in the open position, NA-D maneuvered the lift from the toilet to R56's wheelchair.

On 6/6/18, at 9:37 a.m. NA-H stated R56 required assistance with transfers with two facility staff and a sit to stand lift. NA-H stated she had been with R56 when the lift tipped over and indicated she had been transferring R56 from her recliner to the bathroom and had to have both of the legs extended in order for the lift to be moved close to the recliner. NA-H stated she had raised R56 into a standing position and when she turned the wheel broke and the lift tipped to the left side.

On 6/6/18, at 2:28 p.m. the facility Plant Operation Manager (POM)-A stated he had been notified when the sit to stand lift had tipped while staff transferred R56. He stated he had replaced and secured the caster and indicated he did not understand how the wheel bolt had broken off. POM-A indicated he felt the legs to the lift could not have been in the open position and had put too much pressure when the lift was turned. He stated the legs to the lift were required to be opened while moving the lift to prevent tipping.

On 6/7/18, at 2:15 p.m. R56's medical record and

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incident report dated 11/2/17, were reviewed with the DON. The DON confirmed R56 had fallen during a transfer with a sit to stand lift. She confirmed R56's incident report lacked a thorough analysis and comprehensive assessment of R56's fall on 11/2/17. The DON confirmed the report did not identify whether the legs of the lift had been opened during the maneuvering of the sit to stand lift, and confirmed the information would be a key component in identifying potential root cause of the sit to stand lift tipping over. She confirmed 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.

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F 689	Continued From page 23 A facility policy for use of mechanical lifts and slings was requested and not provided.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This 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: R1's discharge return-anticipated Minimal Data	F 692	Super high calorie cereal was added daily at breakfast, 2oz. Ensure compact supplement added at all medication passes (4x/daily), continued with restorative assisted eating program for a quiet and low stimulus eating environment, and fortified milk added in place of regular 2% milk for drinking purposes, staff to try soft music and hand	7/24/18

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F 692	Continued From page 24 Set (MDS) dated 4/24/18, identified R1 had diagnoses which included anxiety, psychotic disorder and diabetes mellitus. The MDS identified R1 required supervision with eating, weight of 96 pounds and no weight loss of 5% (percent) or more in the last month or loss of 10% or more in last 6 months. However, R1's clinical record documented a weight on 3/24/18, of 101.8 pounds, which represented a significant change in weight with a greater than 5% weight loss in the last month. R1's significant change in status assessment MDS dated 5/16/18, identified R1 had moderately impaired cognition and required extensive 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 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 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) twice daily, and to have no further weight loss. The CAA lacked further analysis of R1's weight loss and considerations	F 692	holding during meal times for appetite stimulation. Residents that triggered with a significant weight loss, will have a comprehensive assessment take place and nutritional interventions will be implemented and adjusted accordingly. Monitoring and evaluating the interventions will be done weekly at IDT meeting. Verbal education on appropriate nutritional interventions relating to weight loss will be conducted at daily Safety Huddles for 1 week. Written education 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 education material via mail with a signature page that must be returned stating that they have read and understood the changes. All residents with significant weight loss will be reviewed weekly at our Medicare Meeting and will be discussed again at care conferences. Audits will be conducted 3 times per week for 4 weeks 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 QAPI meeting. Monitoring will continue until 4 consecutive months of compliance have	

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F 692	Continued From page 25 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 nutrition drink mix provides 95 calories) twice a day. The form indicated R1 required set up assistance at meals with coaching. The form further indicated meal intakes for R1 which included 3 breakfasts at 85%, 2 lunches at 25% and 4 supper meals at 50% with all other meals at 0% or refused and fluids at 755 milliliters (ML) per day. The noted lacked further analysis of possible reasons for R1's weight loss and considerations and interventions to attempt to prevent further weight loss. R1's care plan last revised 6/4/18, identified R1 was required to eat in the assistance dining room for cues and observation and up to assistance of one staff as indicated and R1 would allow due to cognitive deficit. R1's care plan further identified R1 left 25% or more of food uneaten at most meals and had poor average meal time fluid intake as well as a decreased appetite and resulting weight loss related to cognitive deficit and anxiety. R1's goals were to consume 50% of meals as evidenced by intake record and weight	F 692	been attained. Responsible: DON and Director of Nutrition Services	

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will not decline any further, as indicated by weight record. R1's care plan directed staff to monitor intake and weights, provide a regular diet, offer meal replacements and snacks, supplements as ordered, provide a quiet and low stimuli environment at mealtime, provide cues and physical assist with eating as needed, restorative nursing assistant will assist with 3-5 meals per week, and R1 drank excess amounts of milk at mealtime/try to re-direct to eat solid foods and offer protein powder with each glass of milk.

R1's nursing assistant (NA) Care Sheet updated 6/1/18, indicated R1 ate in the assistance dining room, however, lacked any further directions regarding R1's nutrition needs or nutritional interventions.

On 6/6/18, at 11:42 a.m. R1 was assisted by staff to sit at a dining room table in the assistance dining room. R1's place setting included a glass of milk, glass of water, a plate with pork roast, mashed potatoes, corn and sweet potato. NA-B was seated across the table from R1 assisting two other residents to eat. R1 was not eating, but looking around the full dining room. At 11:49 a.m. another NA sat at the table to the left of R1 and assisted another resident to eat. R1 was picking up small pieces of pork with her left hand and taking small bites, along with small sips of water. At 12:02 p.m. R1 was observed to take small bites of pork, a small bite of corn and small sip of milk. At times she would pick up a piece of pork, roll it in her hands and place it back on her plate without attempting to eat. At 12:13 p.m. R1 independently stood up from her chair, reached for her walker, and walked back to her room. R1 had consumed bites of corn and pork and drank approximately 7 ounces of milk and water. No

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staff offered R1 a meal substitute, encouraged R1 to eat, or assisted R1 with her meal during the entire observation.

On 6/7/18, at 8:36 a.m. R1 walked down the hall independently with her walker and sat at a table in the assistance dining room. At 8:39 a.m. R1 remained seated at the table looking at other residents in the room. At 8:45 a.m. staff placed a glass of milk with Pro-pass mixed into it in front of her on the table. At 8:47 a.m. R1 had not attempted to take a drink of milk. AA-L went to the kitchenette and dished up R1's breakfast which consisted of a small bowl of applesauce and two pieces of jellied toast. activities assistant lead (AA)-L sat next to R1, cut up the toast and tried to give R1 a bite of toast. R1 would not open her mouth. AA-L placed a straw in the glass of milk and attempted to get R1 to take a drink of her milk, R1 would not take a drink. AA-L proceeded to offer a spoonful of applesauce, and a bite of toast, with R1 refusing to consistently take bites of the items. AA-L tried multiple more times to get R1 to take a bite of the toast without success and gave her another sip of milk. At 9:07 a.m. AA-L transferred R1 to a wheelchair and brought her back to her room. R1 had consumed sips of milk and two small bites of applesauce. AA-L did not offer any other menu items or alternatives during the breakfast meal.

On 6/7/18, at 11:22 a.m. R1 was lying on her back in bed with eyes closed. At 11:47 a.m. R1 continued the same, as other residents were eating the lunch meal in the dining room. NA-A walked by R1's room as she delivered a tray of food items to a resident in the hall across from R1's room, but did not stop. At 12:14 p.m. R1 remained lying in bed on her back and no staff

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had entered her room. At 12:40 p.m. LPN-A entered R1's room, assisted her to transfer to her recliner, sat next to R1 and assisted her to drink a glass of milk and eat one cookie.

On 6/7/18, at 2:17 p.m. NA-D stated R1 slept through the lunch meal. NA-D stated R1 was hard to get R1 to sit and eat a meal and if she would sit, she would only eat a few bites. NA-D stated R1 returned from an inpatient psychiatric stay in May and getting R1 to eat had been worse than before. She stated R1 used to drink 3-4 glasses of milk at each meal and now only drinks sips of milk.

On 6/7/18, at 2:27 p.m. NA-A stated R1 was tired, very weak and very different after returning from the inpatient psychiatric hospitalization. She stated R1 had to be cued to eat and drink at meals, got up from dining room chairs during meals and wandered between units. NA-A stated the nurse must have directed not to get R1 for lunch, otherwise she would have been in the dining room. On 6/8/18, at 9:00 a.m. in a follow up interview, NA-A stated, "if [R1] is sleeping, then no we don't wake her up, at least that is what the nurses told us."

On 6/7/18, at 2:32 p.m. NA-D stated before R1's inpatient psychiatric stay she was combative and when she came back she was a completely different person. Then R1's physician changed some medications and "woke" her up and now she wanders a lot and has good days and bad. NA-D stated if staff could get R1 to sit down to eat, then R1 would eat a few bites. NA-D stated almost all of R1's food was supplements and that all staff knew they could not get R1 to sit down and focus long enough to eat a meal. She stated

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staff were to offer R1 her meal a couple times and then could chart a refusal of the meal. On 6/8/18, at 9:12 a.m. during a follow up interview, NA-D stated she had not received education regarding nutritional interventions from the restorative nursing program or the nurse manager including to offer finger foods.

On 6/7/18, at 2:47 p.m. licensed practical nurse (LPN)-A stated R1's appetite was very poor and R1 would only take a couple bites at meals. She stated R1 loved milk and staff add Propass to milk and give her one with each medication pass and with meals. LPN-A stated R1 also received Juven twice a day. LPN-A stated last week staff tried sitting R1 facing the window and gave her one item of food at a time, but she still got up from the table and only ate 25%. LPN-A confirmed no staff attempted to wake R1 for the lunch meal. LPN-A stated R1 had lost weight and was currently at 93.5 pounds. LPN-A stated prior to R1's psychiatric hospitalization she was aggressive and would stand near the exit door to the facility and now R1 was more dosile, but would still eat about the same amount.

On 6/7/18, at 2:57 p.m. AA-L stated she was also a trained medication aide and assisted in the dining room every morning she worked. She stated she tried to get R1 to eat breakfast that morning and stated she had not offered R1 any other menu items after the bites of apple sauce, sips of milk or refusal of toast.

Review of R1's weight record from 12/1/17, to 6/2/18, revealed:

-12/1/17, 115 pounds

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F 692	Continued From page 30 -1/5/18, 114 pounds -2/10/18, 108.5 pounds -3/14/18, 104.6 pounds -3/16/18, 102.2 pounds -3/31/18, 100.8 pounds -4/6/18, 99 pounds -4/14/18, 99.2 pounds -4/20/18, 95.5 pounds -5/9/18, 100.2 pounds -5/12/18, 101.4 pounds -5/18/18, 97.5 pounds -5/25/18, 92.5 pounds -6/2/18, 93.5 pounds 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 30 times -April 1-24, 2018, R1 consumed:	F 692		

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100% of the meal 2 times
75% of the meal 1 time
50% of the meal 0 times
25% of the meal 15 times
0% of the meal 26 times
Refused the meal 28 times

-May 9-31, 2018, R1 consumed:

100% of the meal 4 times
75% of the meal 3 times
50% of the meal 8 times
25% of the meal 14 times
0% of the meal 18 times
Refused the meal 20 times

-June 1-4, 2018, R1 consumed:

100% of the meal 0 times
75% of the meal 0 times
50% of the meal 1 time
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.

-5/10/18, R1 did not want breakfast, ate some

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lunch, but not much. Order from dietary manager (DM) to start on Juven supplements twice a day.

-5/11/18, R1 refused to eat.

-5/12/18, R1 slept past breakfast. Current weight 101.4 pounds.

-5/14/18, ate fair for lunch and refused to eat anything for breakfast.

-5/17/18, R1 continued to eat poorly.

-5/23/18, Updated R1's physician on varied appetite, but poor average of 25% at meals. Weight now 97.5 pounds. R1 continued to need one to one for eating and drinking and needs to be fed at times or encouraged to eat and drink.

-5/24/18, R1 slept through supper.

-6/2/18, R1 ate a little for breakfast, had Propass in each milk and Juven at 1000.

-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.

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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 stimulation during meals. She indicated R1 had no specific snacks set up during the day to increase caloric intake.

On 6/7/18, at 3:33 p.m. registered nurse clinical coordinator (RNCC)-B stated R1's significant weight loss was first noted around 3/9/18 and continued until an inpatient psychiatric hospitalization. While hospitalized, R1 gained about 5 pounds, but since back to the facility was losing weight again. RNCC-B indicated R1 was non-stop movement and staff were to offer food and fluids on the run to her. RNCC-B stated R1 would not allow assistance at times in the past, but at present would allow staff to assist her. She stated R1 would at times pop up and down from her chair in the dining room and staff should feed R1 first so they can focus on the meal. She stated a restorative eating program had just been set up

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that week to trail a low stimulated meal environment with staff cueing and assisting as needed. She stated R1's physician recently made some medication adjustments, added Juven and family brought in Oreo's, but now was at the point that she no longer liked Oreo's. RNCC-B stated R1 required supervision and cueing and up to total assistance for eating. She indicated she would have expected staff to cue, encourage and assist R1 with intake, offer R1 all menu options at each meal and offer alternatives if R1 was not eating what was served.

On 6/8/17, at 11:17 a.m. during a follow up interview, DNS-A stated she was aware R1 had lost weight, but was not aware of R1's recent significant change in weight and indicated it was a long standing problem to get R1 to eat. DNS-A indicated she did not routinely complete resident nutritional assessments unless DS-A asked for help. DNS-A stated she had not completed a nutrition assessment for R1 at any time, and was not asked to do so. She indicated she would have assessed R1's labs, medications and specific diagnoses and then tried a few more interventions, including looking at more supplements and documented if they were successful or not.

On 6/8/18, at 11:43 director of nursing (DON) stated R1's gradual weight loss was noted in March. R1 had a period of high anxiety and could not calm down. Nursing and psychiatry adjusted R1's medications, but R1's quality of life continued to decline. R1 was then sent to an inpatient psychiatric hospital and then returned on 5/9/18. DON indicated R1 was eating a little better after her return, but now her anxiety was going up and intake was going down. She stated

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F 692	Continued From page 35 R1 would not sit down to eat and staff should be feeding her on the go. DON expected dietary to order supplements, add snacks, monitor R1's nutritional status and intake closely. DON stated she would have expected the dietician to be notified after a couple weeks of identified weight loss. She stated she would also have expected an assessment from the dietician and to provide assistance with interventions. DON indicated she would have expected staff to cue, encourage and assist R1 as needed during a meal, offer all menu items and alternatives and stated it would be inappropriate to not try and wake R1 if she were sleeping during a meal. 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 dietician if all other options had been tried and the resident continued to lose weight.	F 692		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/18/18

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F 880	Continued From page 36 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 37 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct ongoing surveillance for the infection control program to ensure tracking and trending of viral infections and illness in the facility. In addition, the facility failed to report a suspected influenza outbreak in the facility. In addition, the facility failed to ensure a Legionella program was in place to prevent the spread of infection in the facility. Further, the facility failed to ensure oxygen tubing and nasal cannula were stored in a manner to prevent the potential contamination during the use of oxygen for 1 of 1 resident (R52) who utilized oxygen therapy. This deficient practice had the potential to affect all 66 residents currently residing in the facility. Findings include:	F 880	Ensure Tracking & Trending for Viral illness and infections: Facility developed and implemented a tracking and trending form for all potential viral illness and infections. Will monitor illness tracking form for trends and take appropriate action for prevention of spreading viral illness. Will also monitor proximity of ill residents to healthy residents. Facility implemented a tracking and trending form for all potential resident illness and infections. Verbal education on reporting/tracking potential viral illness/infections will be conducted at daily Safety Huddles for 1 week. Written education will be posted on each neighborhood and staff are required to sign off that they have read and	

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

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F 880	Continued From page 38 A review of the facility's infection control program was conducted on 6/8/18, at 12:03 p.m. with the director of nursing (DON) present. The facility provided copies of daily forms titled: 24-Hour Charge Sheets from 4/1/18 to 4/8/18. The forms listed daily various items such as hospitalizations, hospital returns admissions, and residents who required follow up. The residents who required follow up listed various reasons such as diagnosis of pneumonia and congestive heart failure, increased shortness of breath, change in Coumadin(blood thinner medication) orders, start or increase in anti depressant medication, or change in use of mechanical lift. On 4/1/18, the form listed R9 had a temperature of 99.4, productive cough and had tested positive for influenza A. and had been started on Tamiflu on 4/2/18. On 4/4/18, R9 had been tested for influenza and had been treated for a respiratory symptoms. There was no evidence the facility had reported this suspected outbreak to the department of health. The DON stated the facility utilized the 24 hour charge sheet forms to review informally any resident viral infections in the facility. The DON confirmed the facility did not have a tracking tool for resident viral illness in the building. She stated at the end of the month she would run a report on the antibiotics used in the facility in the previous month, and did not track specific organisms, or viral illness. She stated the infection control program was informal, and confirmed the facility did not look for trends or patterns with viral illness in the facility. DON stated the facility had discussed antibiotic stewardship in the facility, however, the policy for antibiotic stewardship was still in draft form at present and both the nursing and hospital has initiated education for staff on	F 880	understood the changes. Additional training will be conducted with all staff during the annual Skills Day training this month. PRN staff will receive education material via mail with a signature page that must be returned stating that they have read and understood the changes. Staff have been educated at daily huddles to report all resident and staff illnesses to the charge nurse, DON or Infection Preventionist. Charge nurses, DON or Infection Preventionist will then report based on MDH/CDC recommendations. All illness are now tracked and montitored every shift looking for trends and reportable illnesses. A perfomance improvement plan will be implemented and reviewed at next QA meeting. Monitoring will continue until 4 consecutive months of compliance have been attained. Responsible: DON Influenza Outbreak Reporting Facility will report all positive Influenza results to the appropriate state and local authorities. Residents will be identified by monitoring the proximity to those affected and monitoring any like symptoms. Verbal education on reporting all positive influenza to state and local authorities will be conducted at daily Safety Huddles for 1 week. Written education 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 education	

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F 880	Continued From page 39 antibiotic stewardship. Review of the facility policy titled, Infection Prevention and Control Program, revised 12/17, revealed there would be ongoing monitoring for infections among patients and documentation of infections that occur and systems in place to facilitate recognition of increases in infections as well as clusters and outbreaks. Review of the facility policy titled, Outbreak Management, revised on 2/16, revealed the facility would conduct outbreak monitoring and report the outbreak to the appropriate state and local authorities. Review of the Minnesota Department of Health form titled Long Term Care Facility Influenza and RSV Form, 2017-18, defined an outbreak as one laboratory confirmed influenza positive case along with other cases of respiratory illness in a unit. Legionella On 6/6/18, at 6:55 a.m. an observation of a large pond was made outside of the facility's main entrance. The pond was adjacent to the facility's parking lot and had a large fountain in the center. The fountain sprayed water from it's base into the air. At 7:15 a.m. during a facility tour, multiple courtyards were observed. Each courtyard observed had an approximate two-foot water fountain made of stone. A review of the facility's Legionella program was conducted on 6/8/18, at 12:40 p.m. with the plant	F 880	material via mail with a signature page that must be returned stating that they have read and understood the changes. In September, all staff will be reminded of the flu season and our reporting requirements. DON or Infection Control personnel will report all influenza cases to MDH. Influenza cases will also be reported at QA. Responsible: DON Oxygen tubing & nasal cannula storage All staff were educated via the huddle board and daily huddles x 1 week that oxygen tubing/nasal cannula□s must be stored off the floor for contamination prevention. Also discussed if the tubing or nasal cannula do touch the floor it needs to be disposed of and replaced with a brand new one. Resident #52 that had nasal cannula stepped on now has hers secured at bedside. Audits will be completed weekly times 4 weeks and then PRN on residents that have oxygen ordered to ensure the tubing/nasal cannula is positioned appropriately and not resting on the floor. Verbal education on proper storage/handling of oxygen tubing/nasal cannula will be conducted at daily Safety Huddles for 1 week. Written education 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 education material via mail with a signature page that must be returned stating that they have read and understood the changes.	

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F 880	Continued From page 40 operations manager (POM)-A present. POM-A stated an assessment of their campus for water management had not been conducted. He stated the facility policy for 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 are acceptable, the water was acceptable. The POM-A confirmed the facility had several water fountains in the courtyards of the facility that had not been monitored and not been assessed for potential concerns with Legionella. The POM-A provided a copy of the draft policy for review at that time. The Water Management Policy, dated 8/14/17, listed in bold letters on all pages of the policy DRAFT. The draft policy listed examples for how to monitor water quality in various areas of a building. The draft policy did not include specific locations or areas in the facility for monitoring and did not include directions for that monitoring. Review of the form titled, Water Samples Free Chlorine, from 2/16/18 to 6/5/18, revealed a water sample had been tested from a random room in both the long term care and acute care center of the campus weekly. However, the form lacked documentation of any further testing, or monitoring or preventative measures done to reduce the risk of Legionella to grow or spread. Review of policy provided by the facility titled Prevention of Legionnaires Disease, dated 1/18, the water management program would identify areas in the building where Legionella could grow and spread, would determine the control measures to be applied, and implement appropriate monitoring of the areas to prevent the growth and spread of Legionella. The policy listed	F 880	PDSA worksheet for testing change will be completed and a performance improvement plan will be implemented and reviewed at next QA meeting. Monitoring will continue until at least 3 consecutive quarters of compliance have been demonstrated. Responsible: DON Legionella Program Our Water Management Plan has been revised with DRAFT removed from the policy and to include Legionella testing twice a year in affected areas. Until water samples can be tested, all fountains have been drained and taken out of service. The revised policy will be applied to all affected areas. Semi-annual testing for Legionella has been entered into our work order management system which will automatically trigger when the testing needs to be performed. Compliance will be tracked through this system and reported to QAPI annually. Responsible: Facility Manager	

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F 880	Continued From page 41	F 880		

various locations which included showers/sinks. heaters and public water mains. However, the policy did not identify the multiple facility decorative water fountains, and did not include control measures for the decorative water fountains.

R52's quarterly Minimum Data Set (MDS) dated 5/8/18, revealed R52 had moderately impaired cognition and had diagnoses which included pulmonary heart disease, heart failure and anxiety. The MDS also indicated R52 was independent with activities of daily living (ADL's), needed supervision of one staff with transfers and received oxygen therapy.

R52's current signed physician orders dated 5/23/18, revealed R52 had an order for oxygen at two liters per nasal cannula at night, two times per day during evening and night. Oxygen tubing change one time per day every 14 days during night.

R52's current Electronic Medication Record (EMAR) was reviewed from 5/18 to 6/18, revealed R52 was currently receiving oxygen at two liters per nasal cannula at night two times per day during evening and night.

Review of R52's current care plan revised on 5/17/18, indicated R52 was at risk for cardiac instability related to hypertension, congestive heart failure and coronary artery disease with stent placement. R52's care plan listed various intervention which included oxygen as needed per standing orders.

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F 880	Continued From page 42	F 880		

During observations on 6/4/18, at 1:24 p.m. R52 was seated in her wheelchair in her room next to her bed. A oxygen wall unit with bubbler was located on the right side of the wall above R52's recliner. The oxygen wall unit was running, the oxygen tubing was connected to the oxygen wall unit and the tubing and nasal cannula were observed curled up on the floor in front of R52's night stand next to her bed.

-At 1:25 p.m. nursing assistant (NA)-A entered the room, and stepped directly on the oxygen tubing and nasal cannula with her shoes. NA-A proceeded to put a transfer belt around R52's waist, assisted R52 to a standing position and transferred R52 from her wheelchair to her bed while continuing to walk on R52's oxygen tubing and nasal cannula while it laid on the floor in front of her night stand. R52 proceeded to lay down in bed by herself while NA-A got a pillow case out of R52's closet for her pillow.

-At 1:27 p.m. R52 asked the NA-A about her oxygen, NA-A reached down to the floor, picked up R52's oxygen tubing and nasal cannula off the floor and handed it to R52. R52 took the oxygen tubing and applied the nasal cannula part of the tubing into both of her nostrils and wrapped the tubing around her ears independently. R52's oxygen was running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.
-At 2:12 p.m. R52 continued to lay in bed resting with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.
-At 4:19 p.m. R52 continued to lay in bed resting

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F 880	Continued From page 43	F 880		

with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.

During observations on 6/5/18 at 8:51 a.m. R52 was laying in bed resting with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.

On 6/5/18, at 2:41 p.m. NA-A confirmed R52 utilized oxygen when needed and at night. NA-A confirmed the oxygen tubing and nasal cannula was lying on the floor in R52's room and she had not gotten new oxygen tubing or nasal cannula for R52 after it had been lying on the floor and walked on. NA-A indicated she was not aware that she had stepped on the tubing while it was lying on the floor and stated, "I should of got a new one (tubing)."

On 6/7/18 at 9:46 a.m. resident coordinator (RC)-A confirmed R52 wore oxygen when she was feeling short of breath at night and as needed during the day while resting. RC-A indicated the oxygen tubing and nasal cannula should be changed every 14 days by the licensed practical nurses and should be documented in the EMAR. The RC-A indicated she would expect staff to change R52's oxygen tubing and nasal cannula when it was found laying on the floor and staff walked on it. RC-A indicated the oxygen tubing and nasal cannula should of been changed right away.

On 6/7/18 at 3:35 p.m. director of nursing (DON) confirmed R52 wore oxygen and she would

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F 880	Continued From page 44 expect staff to throw the contaminated oxygen tubing away and to get a new one. Review of the facility policy titled, Oxygen Therapy revised on 3/13, indicated nasal cannula tubing and extensions will be changed every two weeks or more often if visibly soiled.	F 880		

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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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building. St Francis Home is part of the St Francis Healthcare Campus. It was built in 2005, is a 1-story building, without a basement and was determined to be Type V (111) construction. It is separated from St Francis Healthcare Center with 3- hour fire barriers and is divided into 4 smoke zones with 1-hour fire barriers. The entire building is completely protected by an automatic fire sprinkler system equipped with quick response sprinkler heads. The Automatic Fire Sprinkler system has been installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has	K 000		

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K 000	Continued From page 2 a manual fire alarm system with smoke detectors throughout the corridor system, in areas open to the corridors, and common areas. The Fire Alarm System has been installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are connected into the fire alarm system and all sleeping rooms have smoke detectors that alarm outside the rooms and at the nurse's station that serves that room. As of July 5, 2016 the facility is considered existing. The facility has a capacity of 80 beds and had a census of 75 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.1 & 7.1.6. and failed to comply with the NFPA 80 Standard for Fire Doors	K 211	All wheelchairs and lifts have been removed from the exit areas and stored in other areas. Education performed through daily safety huddles through July 6 with staff to keep all exits cleared of supplies and equipment.	7/6/18

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K 211	Continued From page 3 and Other Opening Protective's 2010 edition. These deficient practices could affect the exiting ability of an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 observations revealed wheel chairs and a lift were being stored in the exit at the intersection of areas G & F and documentation review revealed the fire door inspections were not conducted in the last 12 months. These deficient conditions were confirmed by the Facilities Manager.	K 211	Responsible: Facility Manager	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler	K 321		7/6/18

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K 321	Continued From page 4 Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 observations revealed room 616 was initially a wheel chair wash. It was converted to storage and did not have a self closing door with a 45 minute rated door. These deficient conditions were confirmed by the Facilities Manager.	K 321	All items not directly related to the washing of wheelchairs has been removed from this area. Room has been restored to it's intended purpose. Reponsible: Facility Manager	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of	K 711		7/18/18

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K 711	Continued From page 5 an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 80 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 documentation review revealed the fire safety plan did not contain the following: 1. Preparation of floors and building for evacuation. 2. No direct call to the fire dept. from the facility. These deficient conditions were confirmed by the Facilities Manager.	K 711	Fire plan has been revised as of 7-2-18 to include preparation of floors and building for evacuation. A section has been added to require a call to the Breckenridge Police dispatch to confirm they have received our signal. Training to all employees for this new process will be completed by July 18, 2018. Responsible: Facility Manager	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		7/2/18

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	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**06/05/2018**

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

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K 712	Continued From page 6 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct fire drills under varied conditions as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 80 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 documentation review revealed the fire drills were not conducted under varied conditions and the drills for the long term care and the hospital were conducted together. These deficient conditions were confirmed by the Facilities Manager.	K 712	We have changed our work order to require separate fire drills for the hospital and long term care. This process began in June. Training was conducted with staff regarding this new process on varied conditions. Responsible: Facility Manager	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and	K 901		7/2/18

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K 901	Continued From page 7 documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all residents, as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 documentation review revealed here was no record of a risk assessment being completed These deficient conditions were confirmed by the Facilities Manager.	K 901	We do a PQE Program Quality Evaluation every year. A copy of this was sent to the Deputy Fire Marshall to show that we have one and it is done annually. This was approved by the Deputy Fire Marshall via email on 7-2-18. Responsible: Facility Manager	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		7/13/18

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K 914	Continued From page 8 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 80 of 80 residents as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 documentation review revealed there was no record of receptacle inspections in the last 12 months. These deficient conditions were confirmed by the Facilities Manager.	K 914	We have begun testing all outlets in the nursing home. Testing includes polarity, proper grounding and tension. A work order will be generated to test these annually. Responsible: Facility Manger	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet	K 923		7/2/18

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K 923	Continued From page 9 Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to label oxygen storage rooms in accordance with NFPA 99 (Health Care Facilities	K 923	Proper signage was ordered and installed on these doors. Responsible: Facility Manager	

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K 923	Continued From page 10 Code) 2012 edition section 11.3.4.1. This condition could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 06/05/2018 observations revealed oxygen storage rooms 880 & 980 were not identified with the proper sign-age. These deficient conditions were confirmed by the Facilities Manager.	K 923		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

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
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00818	A. BUILDING: _____ 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/4/18 through 6/8/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		7/18/18

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2 540	Continued From page 3 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 affect appetite or nutritional needs, medications and environmental factors. Each of the above pre-populated areas	2 540	Corrected	

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2 540	Continued From page 4	2 540		

had a comment area where staff could add additional information/analysis of the identified problems, but each of the six comment areas were blank. Under the heading Analysis of Findings, the instructions indicated "Review Indicators & Supporting Documentation & Draw Conclusions. Document the Following: Description of the Problem, Causes and Contributing Factors, Risk Factors Related to the Care Area" however, the comment section for this was left blank. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks, which impacted R1's nutritional status. The CAA further lacked any other considerations that could affect R1's nutritional status from resident observation and resident and/or representative input for care planning considerations.

Review of facility provided Resident CAA Audit Trail for R1 dated 5/25/18, indicated the CAA type was Nutritional Status. The Audit Trail had 3 CAA questions with answers. The first question was "Cardiac Drugs", with an answer of "No". The second question was "Current Eating Pattern Comment", with an answer of "Significant Change conference was held on 5/24/18. See chart note from the conference". The third question was "Care Planning Decision Comment", with the answer "Proceed to care plan. CAA, Care Plan, Risk Assessment, etc, completed/updated."

Review of R1's significant change care conference chart note dated 5/25/18, indicated R1's weight was 98 pounds, which was down 14 pounds since February, 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

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2 540	Continued From page 5 (nutritional supplement) twice daily, and to have no further weight loss. The note lacked any further documentation of analysis of the reasons for continued weight loss and lacked further considerations or interventions to attempt to prevent further weight loss. On 6/8/18, at 11:25 a.m. dietary supervisor (DS)-A confirmed she completed R1's Nutritional Status CAA dated 5/29/18. DS-A indicated her usual practice was to input information in the CAA and answer the questions, then would complete a chart note. DS-A stated the chart note was the CAA. DS-A stated she felt R1's Nutritional Status CAA was a comprehensive analysis of R1's nutritional status. On 6/8/18, at 11:43 a.m. director of nursing (DON) stated she would expect R1's Nutritional Status CAA to be a comprehensive assessment of her individual nutrition needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies, educate staff and then perform random audits to ensure each resident is comprehensively assessed using the Resident Assessment Instrument (RAI) process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	2 830		7/18/18

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2 830	Continued From page 6 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess the safe use of a mechanical lift for 2 of 2 residents (R53, R56) reviewed who experienced falls from sit to stand lifts. Findings include: R53's admission Minimum Data Set dated, identified R53 had severe cognitive impairment and had diagnosis which included malnutrition, dementia and stage four (4) decubitus ulcer. The MDS revealed R53 had difficulty with recall and temporal orientation. The MDS revealed R53 required extensive assistance of two facility staff for activities of daily living (ADL's,) including transfers, bed mobility and locomotion with a wheelchair. R53's admission Care Area Assessment (CAA) dated 4/30/18, identified R53 had severe cognitive impairment and required physical assistance from facility staff for ADL's. The CAA indicated R53 had significant malnutrition.	2 830	Corrected	

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2 830	Continued From page 7 R53's fall risk assessment dated, 4/29/18, identified R53 was at high risk for falls due included the following indicators; easily distracted, periods of altered perception or awareness of surroundings, restlessness, impaired cognition, vision, mobility, balance, age, medications and health conditions. R53's care plan revised 6/4/18, revealed R53 had cognitive impairment, was at risk for falls and required assistance with transfers using a transfer belt, pivot disk and two assist. R53's fall incident report dated 5/16/18, revealed R53 had been assisted to transfer with a sit to stand mechanical lift (stand up lift, SUL) from a wheelchair to bed. The incident report revealed R53 had let go of the handles on the lift and slid through the sling and onto the floor of her room. R53's incident report revealed an immediate intervention had been implemented to assist R53 to transfer with 2 assist and a full body lift (FBL.) R53's fall incident report updated 5/22/18, revealed R53's fall was an unanticipated move and had no further falls with the use of the FBL with two assist. On 6/6/18, at 7:32 a.m. R53 was seated in a wheelchair in front of the low counter in the kitchen area of the neighborhood unit. R53 ate her breakfast and asked staff where her breakfast was, while she held a banana in her right hand. 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	2 830		

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2 830	Continued From page 8 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 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 fallen while she was assisted to transfer using a sit to stand lift. The DON stated 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, (used for average sized adults) and indicated the brand of sit to stand lifts used by the facility did not offer sizes of small, medium or large. However, she indicated the facility's FBL's had sized slings. The DON confirmed R53 had a diagnosis of malnutrition and felt she was a small sized woman. The DON confirmed R53's medical record lacked a comprehensive assessment of	2 830		

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2 830	Continued From page 9	2 830		

R53's fall from the sit to stand lift on 5/16/18, which would have included potential causative factors, a root cause analysis, post fall assessment and fall risk assessment. She stated she would expect the slings to be tightened during a lift in order for the sling to secure the resident during a transfer. The DON stated the facility did not have a formal system for ensuring residents using the universal slings for the sit to stand lift were the appropriate size for residents with a small stature. Further the DON confirmed R53's medical record lacked documentation whether the universal sling had been an appropriate size for R53.

On 6/7/18, at 2:47 p.m. the SO-A stated she had been unaware of R53's fall from the sit to stand lift. The SO-A stated the slings for the sit to stand lifts used a universally sized sling and indicated the sling was to be tightened while the resident was raised in the air in order to maintain safety to ensure residents do not slide through the sling. She indicated she felt a universal sling would not necessarily be appropriate for smaller stature residents.

On 6/7/18, at 3:19 p.m. registered nurse (RN)-A stated she had spoken with the NA which was present at the time of the fall and she had indicated the sling used on R53 was a universal sling which had been tightened 2-3 times while she had been raised in the air. RN-A stated R53 had then let go of the handles of the lift and had slid through the sling.

On 6/8/18, at 9:38 a.m. NA-G stated she felt the universal sling used with the facility's sit to stand lift did not fit R53. NA-G stated she felt R53 was very forgetful and would not be able to hold onto the lifts handles for long without verbal cues. She

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2 830	Continued From page 10 stated the FBL's had various sized slings and residents were to be measured for the appropriate sling. On 6/8/18, at 11:11 a.m. registered nurse clinical coordinator (RNCC)-A stated her usual process for assessing residents transfer needs included the resident's ability to bear weight, follow direction, weight and overall body frame. RNCC-A stated she felt the universal sling used for R53 may not have fit her small frame and could have contributed to her fall from the sit to stand lift on 5/16/18. On 6/8/18, at 11:16 a.m. LPN-D stated she had been on duty the day R53 had fallen on 5/16/18. She stated the NA on duty had tightened the straps of the sling across R53's chest while she had lifted her from her wheelchair to bed. She stated R53 had then let go of the lifts handles and slid through the sling despite the sling straps being tightened. On 6/8/18, at 11:45 a.m. a telephone interview was conducted with a customer service representative from SMT (Sunrise Machine and Tool) Health Systems (manufacturer of the sit to stand lift utilized by the facility.) He indicated the facility used a universal sling for the sit to stand lift and he was not able to identify weight or measurement restrictions for use with the universal sling. He stated it was the facility's responsibility to ensure the sling was an appropriate fit for residents. The representative stated the sling strap was to be tightened while the resident was lifted to prevent sliding through the sling. He stated he felt if a resident slid through the universal sling after it was tightened, then the sling was not safe to use.	2 830		

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2 830	Continued From page 11 Review of an undated operator manual for the Volaro PA600/PA600S sit to stand lift, identified applying the sling properly was the most important part of the lifting experience to ensure patient safety. The manual instructed staff to tighten the straps of the sling while the patient was in the lift to keep the sling snug. 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. R56's quarterly MDS dated 5/11/18, identified R56 was cognitively intact and had diagnoses which included anemia, congestive heart failure and hemiplegia (one sided paralysis.) The MDS identified R56 had bilateral upper extremity impairment and required extensive assistance of two staff for ADL's including bed mobility and transfers. The MDS identified R56 had no falls since the last quarterly assessment. R56's CAA's dated 9/19/17, identified R56 required assistance from staff and a sit to stand lift for transfers and indicated two staff should assist R56 when she was not feeling well or if the staff were not familiar with her. The CAA indicated R56 had no recent falls. R56's fall risk assessment dated 5/9/18, identified she was at risk for falls. R56's care plan revised 5/17/18, identified R56 was at risk for falls and required extensive assistance of two facility staff and the sit to stand	2 830		

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2 830	Continued From page 12 lift for transfers. R56's incident details report dated 11/217, revealed R56 had been transferred with a sit to stand lift and one facility staff assistance from her bed to the bathroom. The report revealed when the NA turned the lift to maneuver it into the bathroom the lift tipped to the left and R56 was lowered to the floor. R56's incident report identified the wheel to the lift had broken off. The report revealed the facility's maintenance manager had immediately removed the lift from service and Biomed had taken the lift for service. The report revealed R56 was to be assisted to transfer with two staff and a sit to stand lift. The report did not identify whether the legs to the lift had been open or closed at the time of the fall. A facility work order dated 11/2/17, revealed the sit to stand lift staff had used to transfer R56 in the aforementioned fall, was lift model PA600, serial number A8700. The order revealed the lift had a broken bolt on the left front castor of the wheel. On 6/4/18, at 1:57 p.m. R56 stated she had fallen a while back from a lift. She indicated the wheel had broken and the lift tipped over. R56 stated since then, she had to have two staff assist her with transfers with the sit to stand lift. During a follow up interview on 6/7/18, at 8:58 a.m. R56 stated she could not recall whether the legs of the sit to stand lift were opened at the time the lift had tipped over. On 6/6/18, at 7:19 a.m. R56 was assisted to transfer from the toilet to her wheelchair by NA-F and NA-D. While NA-D used the lift controls to lift R56 from the toilet, NA-F tightened the straps of the sling. NA-D then pulled the left away from the	2 830		

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2 830	Continued From page 13	2 830		

toilet, while both legs of the lift were in the open position, NA-D maneuvered the lift from the toilet to R56's wheelchair.

On 6/6/18, at 9:37 a.m. NA-H stated R56 required assistance with transfers with two facility staff and a sit to stand lift. NA-H stated she had been with R56 when the lift tipped over and indicated she had been transferring R56 from her recliner to the bathroom and had to have both of the legs extended in order for the lift to be moved close to the recliner. NA-H stated she had raised R56 into a standing position and when she turned the wheel broke and the lift tipped to the left side.

On 6/6/18, at 2:28 p.m. the facility Plant Operation Manager (POM)-A stated he had been notified when the sit to stand lift had tipped while staff transferred R56. He stated he had replaced and secured the caster and indicated he did not understand how the wheel bolt had broken off. POM-A indicated he felt the legs to the lift could not have been in the open position and had put too much pressure when the lift was turned. He stated the legs to the lift were required to be opened while moving the lift to prevent tipping.

On 6/7/18, at 2:15 p.m. R56's medical record and incident report dated 11/2/17, were reviewed with the director of nursing (DON). The DON confirmed R56 had fallen during a transfer with a sit to stand lift. She confirmed R56's incident report lacked a thorough analysis and comprehensive assessment of R56's fall on 11/2/17. The DON confirmed the report did not identify whether the legs of the lift had been opened during the maneuvering of the sit to stand lift, and confirmed the information would be a key component in identifying potential root cause of the sit to stand lift tipping over. She confirmed

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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 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. In addition, the director of maintenance could review/revise policies on mechanical lift	2 830		

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2 830	Continued From page 15 maintenance to ensure the manufacturer instructions were being followed, set up a routine maintenance plan and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently implement pressure relieving interventions for 1 of 1 resident (R7) reviewed at risk for pressure ulcers. Findings include: R7's admission Minimum Data Set (MDS) dated	2 900	Corrected	7/18/18

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2 900	Continued From page 16 10/2/17 identified R7 had severely impaired cognition and diagnoses which included; Alzheimer's disease, dementia and anemia. The MDS identified R7 was totally dependent on staff for all activities of daily living (ADLs), did not walk. Further, R7's MDS identified R7 was at risk for the development of pressure ulcers, and was on a turning and repositioning program. R7's quarterly MDS, dated 3/9/18, identified R7 had severely impaired cognition, was totally dependent on staff for ADLs, remained at risk for development of pressure ulcers and was not on a turning repositioning program. R7's admission Care Area Assessment (CAA) dated 10/20/17, revealed R7 had risk factors for development of pressure ulcers of immobility with a functional limitation in range of motion, incontinence, cognitive loss with a diagnosis of Alzheimer's disease and required a regular turning schedule. R7's CAA listed her skin was intact with exception of a dry scab on her right foot under the pinky toe. The CAA directed to prevent skin breakdown R7 was to wear blue heel protector boots at all times, and turn and reposition every 2 to 3 hours. 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 and bed linens with nursing assistant(NA)-F and NA-G present in the room. R7 had blue heel	2 900		

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2 900	Continued From page 17	2 900		

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 NAG-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 protectors from her wheelchair and placed them on R7's feet with the heels in the heel cut outs correctly and placed a pillow under her right side to reposition her off of her buttocks.

On 6/6/18 continuous observations were conducted from 1:25 p.m. to 2:25 p.m. At 1:25 p.m. NA-F and NA-G were present with R7 in her room and assisted her to transfer from her Broda chair to bed leaving the blue heel protectors in place on the foot board of R7's wheelchair. NA-F and NA-G proceeded to assist R7 with personal cares and position her with a pillow behind her back onto her side with her heels resting directly on the mattress. R7's blue heel protectors were observed on the footboard of the Broda chair and no pillows were placed under R7's feet or lower legs. At 1:35 p.m. licensed practical nurse (LPN)-C entered R7's room and NA-F and NA-G exited

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2 900	Continued From page 18	2 900		

R7's room. LPN-C assessed R7's ears while R7's heels rested directly on the mattress of the bed. LPN-C exited the room without placing the blue heel protector boots or pillows under R7's heels. R7's blue heel protectors remained in the Broda chair and no pillows was present under or near R7's feet and heels. At 1:52 p.m. LPN-C walked past R7's room, but did not enter R7's room. R7's heels remained in the same position, directly on the mattress of the bed. At 1:59 p.m. laundry personnel briefly entered R7's room and exited. No other staff entered her room.

At 2:10 p.m., NA-F stated R7 did not move on her own, was very rigid and was total assistant with cares. She indicated R7 was to wear the blue heel boots at all times and was to be repositioned every 2 hours.

At 2:15 p.m. NA-G stated R7 required total cares for all activities of daily living due to being too rigid. NA-G stated R7 was to be repositioned every two hours and indicated R7 was to wear the blue heel boots at all times.

At 2:21 p.m. R7 remained in the same position, with both heels resting directly on the mattress of the bed. LPN-C was notified of R7's heels resting directly on the mattress at that time.

At 2:22 p.m. LPN-C stated R7 only utilized the blue heel protectors while in the chair, and was not aware if she wore the heel protectors at night. After review of R7's care plan, LPN-C stated R7 was to wear the blue heel protectors at all times. She indicated R7's left heel was softer than the right heel but did not have any open areas at present. She indicated R7's heels had been red in the past, and she would expect the heel protectors to be on at all times. At 2:25 p.m., R7's

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2 900	Continued From page 19 heels were observed with LPN-C who confirmed the observation. R7's both heels had dry skin, and left heel was soft, mushy, and readily indented when LPN-C palpated the area although there were no open areas noted. On 6/6/18 at 2:32 p.m. RN clinical coordinator (RNCC)-A confirmed R7 was at risk for pressure ulcer development due to her dementia, decreased mobility and did not move on her own. She stated she would expect R7's heels to be floated off the mattress or in the blue heel protectors at all times, not resting directly on the mattress because of R7's potential for pressure ulcer development On 6/8/18 at 12:00 p.m. the director of nursing (DON) confirmed R7 was at risk for pressure ulcers due to her immobility and her inability to move herself. She stated she would expect staff to follow R7's care plan for pressure ulcer prevention. A policy for pressure ulcer prevention was requested, but not provided by facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. 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: R1's discharge return-anticipated Minimal Data Set (MDS) dated 4/24/18, identified R1 had diagnoses which included anxiety, psychotic disorder and diabetes mellitus. The MDS identified R1 required supervision with eating, weight of 96 pounds and no weight loss of 5% (percent) or more in the last month or loss of 10% or more in last 6 months. However, R1's clinical record documented a weight on 3/24/18, of 101.8 pounds, which represented a significant change in weight with a greater than 5% weight loss in the last month. R1's significant change in status assessment MDS dated 5/16/18, identified R1 had moderately impaired cognition and required extensive	2 965	Corrected	7/18/18

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2 965	Continued From page 21	2 965		

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 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 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) twice 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

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2 965	Continued From page 22 nutrition drink mix provides 95 calories) twice a day. The form indicated R1 required set up assistance at meals with coaching. The form further indicated meal intakes for R1 which included 3 breakfasts at 85%, 2 lunches at 25% and 4 supper meals at 50% with all other meals at 0% or refused and fluids at 755 milliliters (ML) per day. The noted lacked further analysis of possible reasons for R1's weight loss and considerations and interventions to attempt to prevent further weight loss. R1's care plan last revised 6/4/18, identified R1 was required to eat in the assistance dining room for cues and observation and up to assistance of one staff as indicated and R1 would allow due to cognitive deficit. R1's care plan further identified R1 left 25% or more of food uneaten at most meals and had poor average meal time fluid intake as well as a decreased appetite and resulting weight loss related to cognitive deficit and anxiety. R1's goals were to consume 50% of meals as evidenced by intake record and weight will not decline any further, as indicated by weight record. R1's care plan directed staff to monitor intake and weights, provide a regular diet, offer meal replacements and snacks, supplements as ordered, provide a quiet and low stimuli environment at mealtime, provide cues and physical assist with eating as needed, restorative nursing assistant will assist with 3-5 meals per week, and R1 drank excess amounts of milk at mealtime/try to re-direct to eat solid foods and offer protein powder with each glass of milk. R1's nursing assistant (NA) Care Sheet updated 6/1/18, indicated R1 ate in the assistance dining room, however, lacked any further directions regarding R1's nutrition needs or nutritional interventions.	2 965		

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2 965	Continued From page 23 On 6/6/18, at 11:42 a.m. R1 was assisted by staff to sit at a dining room table in the assistance dining room. R1's place setting included a glass of milk, glass of water, a plate with pork roast, mashed potatoes, corn and sweet potato. NA-B was seated across the table from R1 assisting two other residents to eat. R1 was not eating, but looking around the full dining room. At 11:49 a.m. another NA sat at the table to the left of R1 and assisted another resident to eat. R1 was picking up small pieces of pork with her left hand and taking small bites, along with small sips of water. At 12:02 p.m. R1 was observed to take small bites of pork, a small bite of corn and small sip of milk. At times she would pick up a piece of pork, roll it in her hands and place it back on her plate without attempting to eat. At 12:13 p.m. R1 independently stood up from her chair, reached for her walker, and walked back to her room. R1 had consumed bites of corn and pork and drank approximately 7 ounces of milk and water. No staff offered R1 a meal substitute, encouraged R1 to eat, or assisted R1 with her meal during the entire observation. On 6/7/18, at 8:36 a.m. R1 walked down the hall independently with her walker and sat at a table in the assistance dining room. At 8:39 a.m. R1 remained seated at the table looking at other residents in the room. At 8:45 a.m. staff placed a glass of milk with Pro-pass mixed into it in front of her on the table. At 8:47 a.m. R1 had not attempted to take a drink of milk. AA-L went to the kitchenette and dished up R1's breakfast which consisted of a small bowl of applesauce and two pieces of jellied toast. activities assistant lead (AA)-L sat next to R1, cut up the toast and tried to give R1 a bite of toast. R1 would not open her mouth. AA-L placed a straw in the glass of	2 965		

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2 965	Continued From page 24	2 965		

milk and attempted to get R1 to take a drink of her milk, R1 would not take a drink. AA-L proceeded to offer a spoonful of applesauce, and a bite of toast, with R1 refusing to consistently take bites of the items. AA-L tried multiple more times to get R1 to take a bite of the toast without success and gave her another sip of milk. At 9:07 a.m. AA-L transferred R1 to a wheelchair and brought her back to her room. R1 had consumed sips of milk and two small bites of applesauce. AA-L did not offer any other menu items or alternatives during the breakfast meal.

On 6/7/18, at 11:22 a.m. R1 was lying on her back in bed with eyes closed. At 11:47 a.m. R1 continued the same, as other residents were eating the lunch meal in the dining room. NA-A walked by R1's room as she delivered a tray of food items to a resident in the hall across from R1's room, but did not stop. At 12:14 p.m. R1 remained lying in bed on her back and no staff had entered her room. At 12:40 p.m. LPN-A entered R1's room, assisted her to transfer to her recliner, sat next to R1 and assisted her to drink a glass of milk and eat one cookie.

On 6/7/18, at 2:17 p.m. NA-D stated R1 slept through the lunch meal. NA-D stated R1 was hard to get R1 to sit and eat a meal and if she would sit, she would only eat a few bites. NA-D stated R1 returned from an inpatient psychiatric stay in May and getting R1 to eat had been worse than before. She stated R1 used to drink 3-4 glasses of milk at each meal and now only drinks sips of milk.

On 6/7/18, at 2:27 p.m. NA-A stated R1 was tired, very weak and very different after returning from the inpatient psychiatric hospitalization. She stated R1 had to be cued to eat and drink at

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2 965	Continued From page 25	2 965		

meals, got up from dining room chairs during meals and wandered between units. NA-A stated the nurse must have directed not to get R1 for lunch, otherwise she would have been in the dining room. On 6/8/18, at 9:00 a.m. in a follow up interview, NA-A stated, "if [R1] is sleeping, then no we don't wake her up, at least that is what the nurses told us."

On 6/7/18, at 2:32 p.m. NA-D stated before R1's inpatient psychiatric stay she was combative and when she came back she was a completely different person. Then R1's physician changed some medications and "woke" her up and now she wanders a lot and has good days and bad. NA-D stated if staff could get R1 to sit down to eat, then R1 would eat a few bites. NA-D stated almost all of R1's food was supplements and that all staff knew they could not get R1 to sit down and focus long enough to eat a meal. She stated staff were to offer R1 her meal a couple times and then could chart a refusal of the meal. On 6/8/18, at 9:12 a.m. during a follow up interview, NA-D stated she had not received education regarding nutritional interventions from the restorative nursing program or the nurse manager including to offer finger foods.

On 6/7/18, at 2:47 p.m. licensed practical nurse (LPN)-A stated R1's appetite was very poor and R1 would only take a couple bites at meals. She stated R1 loved milk and staff add Propass to milk and give her one with each medication pass and with meals. LPN-A stated R1 also received Juven twice a day. LPN-A stated last week staff tried sitting R1 facing the window and gave her one item of food at a time, but she still got up from the table and only ate 25%. LPN-A confirmed no staff attempted to wake R1 for the lunch meal. LPN-A stated R1 had lost weight and

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2 965	Continued From page 26 was currently at 93.5 pounds. LPN-A stated prior to R1's psychiatric hospitalization she was aggressive and would stand near the exit door to the facility and now R1 was more dosile, but would still eat about the same amount. On 6/7/18, at 2:57 p.m. AA-L stated she was also a trained medication aide and assisted in the dining room every morning she worked. She stated she tried to get R1 to eat breakfast that morning and stated she had not offered R1 any other menu items after the bites of apple sauce, sips of milk or refusal of toast. Review of R1's weight record from 12/1/17, to 6/2/18, revealed: -12/1/17, 115 pounds -1/5/18, 114 pounds -2/10/18, 108.5 pounds -3/14/18, 104.6 pounds -3/16/18, 102.2 pounds -3/31/18, 100.8 pounds -4/6/18, 99 pounds -4/14/18, 99.2 pounds -4/20/18, 95.5 pounds -5/9/18, 100.2 pounds -5/12/18, 101.4 pounds -5/18/18, 97.5 pounds	2 965		

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2 965	Continued From page 27 -5/25/18, 92.5 pounds -6/2/18, 93.5 pounds 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 30 times -April 1-24, 2018, R1 consumed: 100% of the meal 2 times 75% of the meal 1 time 50% of the meal 0 times 25% of the meal 15 times 0% of the meal 26 times Refused the meal 28 times -May 9-31, 2018, R1 consumed: 100% of the meal 4 times 75% of the meal 3 times 50% of the meal 8 times 25% of the meal 14 times 0% of the meal 18 times Refused the meal 20 times -June 1-4, 2018, R1 consumed: 100% of the meal 0 times 75% of the meal 0 times 50% of the meal 1 time	2 965		

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2 965	Continued From page 28 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. -5/10/18, R1 did not want breakfast, ate some lunch, but not much. Order from dietary manager (DM) to start on Juven supplements twice a day. -5/11/18, R1 refused to eat. -5/12/18, R1 slept past breakfast. Current weight 101.4 pounds. -5/14/18, ate fair for lunch and refused to eat anything for breakfast. -5/17/18, R1 continued to eat poorly. -5/23/18, Updated R1's physician on varied appetite, but poor average of 25% at meals. Weight now 97.5 pounds. R1 continued to need one to one for eating and drinking and needs to be fed at times or encouraged to eat and drink. -5/24/18, R1 slept through supper. -6/2/18, R1 ate a little for breakfast, had Propass in each milk and Juven at 1000.	2 965		

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2 965	Continued From page 29 -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 stimulation during meals. She indicated R1 had no specific snacks set up during the day to increase caloric intake.	2 965		

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2 965	Continued From page 30 On 6/7/18, at 3:33 p.m. registered nurse clinical coordinator (RNCC)-B stated R1's significant weight loss was first noted around 3/9/18 and continued until an inpatient psychiatric hospitalization. While hospitalized, R1 gained about 5 pounds, but since back to the facility was losing weight again. RNCC-B indicated R1 was non-stop movement and staff were to offer food and fluids on the run to her. RNCC-B stated R1 would not allow assistance at times in the past, but at present would allow staff to assist her. She stated R1 would at times pop up and down from her chair in the dining room and staff should feed R1 first so they can focus on the meal. She stated a restorative eating program had just been set up that week to trail a low stimulated meal environment with staff cueing and assisting as needed. She stated R1's physician recently made some medication adjustments, added Juven and family brought in Oreo's, but now was at the point that she no longer liked Oreo's. RNCC-B stated R1 required supervision and cueing and up to total assistance for eating. She indicated she would have expected staff to cue, encourage and assist R1 with intake, offer R1 all menu options at each meal and offer alternatives if R1 was not eating what was served. On 6/8/17, at 11:17 a.m. during a follow up interview, DNS-A stated she was aware R1 had lost weight, but was not aware of R1's recent significant change in weight and indicated it was a long standing problem to get R1 to eat. DNS-A indicated she did not routinely complete resident nutritional assessments unless DS-A asked for help. DNS-A stated she had not completed a nutrition assessment for R1 at any time, and was not asked to do so. She indicated she would have assessed R1's labs, medications and specific diagnoses and then tried a few more	2 965		

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2 965	Continued From page 31	2 965		

interventions, including looking at more supplements and documented if they were successful or not.

On 6/8/18, at 11:43 director of nursing (DON) stated R1's gradual weight loss was noted in March. R1 had a period of high anxiety and could not calm down. Nursing and psychiatry adjusted R1's medications, but R1's quality of life continued to decline. R1 was then sent to an inpatient psychiatric hospital and then returned on 5/9/18. DON indicated R1 was eating a little better after her return, but now her anxiety was going up and intake was going down. She stated R1 would not sit down to eat and staff should be feeding her on the go. DON expected dietary to order supplements, add snacks, monitor R1's nutritional status and intake closely. DON stated she would have expected the dietician to be notified after a couple weeks of identified weight loss. She stated she would also have expected an assessment from the dietician and to provide assistance with interventions. DON indicated she would have expected staff to cue, encourage and assist R1 as needed during a meal, offer all menu items and alternatives and stated it would be inappropriate to not try and wake R1 if she were sleeping during a meal.

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

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2 965	Continued From page 32 dietician if all other options had been tried and the resident continued to lose weight. SUGGESTED METHOD OF CORRECTION: The Dietician could review/revise facility policies regarding residents at nutritional risk, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct ongoing surveillance for the infection control program to ensure tracking and trending of viral infections and illness in the facility. In addition, the facility failed to report a suspected influenza outbreak in the facility. In addition, the faciilty failed to ensure a Legionella program was in place to prevent the spread of infection in the facility. Further, the facility failed to ensure oxygen tubing and nasal cannula were stored in a manner to prevent the potential contamination during the use of oxygen for 1 of 1 resident (R52) who utilized oxygen therapy. This deficient practice had the potential	21375	Corrected	7/18/18

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to affect all 66 residents currently residing in the facility.

Findings include:

A review of the facility's infection control program was conducted on 6/8/18 at 12:03 p.m. with the director of nursing (DON) present. The facility provided copies of daily forms titled 24-Hour Charge Sheets from 4/1/18 to 4/8/18. The forms listed daily various items such as hospitalizations, hospital returns admissions, and residents who required follow up. The residents who required follow up listed various reasons such as diagnosis of pneumonia and congestive heart failure, increased shortness of breath, change in Coumadin(blood thinner medication) orders, start or increase in anti depressant medication, or change in use of mechanical lift. On 4/1/18 the form listed R9 had a temperature of 99.4 , productive cough and had tested positive for influenza A. and had been started on Tamiflu on 4/2/18. On 4/4/18, R29 had been tested for influenza and ND had been treated for a respiratory symptoms. There was no evidence the facility had reported this suspected outbreak to the department of health.

The DON stated the facility utilized the 24 hour charge sheet forms to review informally any resident viral infections in the facility. The DON confirmed the facility did not have a tracking tool for resident viral illness in the building. She stated at the end of the month she would run a report on the antibiotics used in the facility in the previous month, and did not track specific organisms, or viral illness. She stated the infection control program was informal, and confirmed the facility did not look for trends or patterns with viral illness in the facilty. DON stated the facility had

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discussed antibiotic stewardship in the facility, however, the policy for antibiotic stewardship was still in draft form at present and both the nursing and hospital has initiated education for staff on antibiotic stewardship.

Review of the facility policy titled infection Prevention and Control Program, revised 12/17, revealed there would be ongoing monitoring for infections among patients and documentation of infections that occur and systems in place to facilitate recognition of increases in infections as well as clusters and outbreaks.

Review of the facilty policy titled Outbreak Management, revised on 2/16, revealed the facility would conduct outbreak monitoring and report the outbreak to the appropriate state and local authorities.

Review of the Minnesota Department of Health form titled Long Term Care Facility Influenza and RSV Form, 2017-18, defined an outbreak as one laboratory confirmed influenza positive case along with other cases of respiratory illness in a unit.

Legionella

On 6/6/18, at 6:55 a.m. an observation of a large pond was made outside of the facility's main entrance. The pond was adjacent to the facility's parking lot and had a large fountain in the center. The fountain sprayed water from it's base into the air.

At 7:15 a.m. during a facility tour, multiple courtyards were observed. Each courtyard observed had an approximate two-foot water fountain made of stone.

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21375	Continued From page 35 A review of the facility's Legionella program was conducted on 6/8/18 at 12:40 p.m. with the plant operations manager (POM)-A present. POM-A stated an assessment of their campus for water management had not been conducted. He stated the facilty policy for 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 are acceptable, the water was acceptable. The POM-A confirmed the facilty had several water fountains in the courtyards of the facility that had not been monitored and not been assessed for potential concerns with Legionella. The POM-A provided a copy of the draft policy for review at that time. The Water Management Policy, dated 8/14/17, listed in bold letters on all pages of the policy DRAFT. The draft policy listed examples for how to monitor water quality in various areas of a building. The draft policy did not include specific locations or areas in the facility for monitoring and did not include directions for that monitoring. Review of the form titled Water Samples Free Chlorine, from 2/16/18 to 6/5/18, revealed a water sample had been tested from a random room in both the long term care and acute care center of the campus weekly. However, the form lacked documentation of any further testing, or monitoring or preventative measures done to reduce the risk of Legionella to grow or spread. Review of policy provided by the facility titled Prevention of Legionnaires Disease, dated 1/18, the water management program would identify areas in the building where Legionella could grow and spread, would determine the control measures to be applied, and implement	21375		

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appropriate monitoring of the areas to prevent the growth and spread of Legionella. The policy listed various locations which included showers/sinks. heaters and public water mains. However, the policy did not identify the multiple facility decorative water fountains, and did not include control measures for the decorative water fountains.

R52's quarterly Minimum Data Set (MDS) dated 5/8/18, revealed R52 had moderately impaired cognition and had diagnoses which included pulmonary heart disease, heart failure and anxiety. The MDS also indicated R52 was independent with activities of daily living (ADL's), needed supervision of one staff with transfers and received oxygen therapy.

R52's current signed physician orders dated 5/23/18, revealed R52 had an order for oxygen at two liters per nasal cannula at night, two times per day during evening and night. Oxygen tubing change one time per day every 14 days during night.

R52's current electronic medication record (EMAR) was reviewed from 5/18 to 6/18, revealed R52 was currently receiving oxygen at two liters per nasal cannula at night two times per day during evening and night.

Review of R62's current care plan revised on 5/17/18, indicated R52 was at risk for cardiac instability related to hypertension, congestive heart failure and coronary artery disease with stent placement. R52's care plan listed various intervention which included oxygen as needed per standing orders.

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During observations on 6/4/18 at 1:24 p.m. R52 was seated in her wheelchair in her room next to her bed. A oxygen wall unit with bubbler was located on the right side of the wall above R52's recliner. The oxygen wall unit was running, the oxygen tubing was connected to the oxygen wall unit and the tubing and nasal cannula were observed curled up on the floor in front of R52's night stand next to her bed.

-At 1:25 p.m. nursing assistant (NA)-A entered the room, and stepped directly on the oxygen tubing and nasal cannula with her shoes. NA-A proceeded to put a transfer belt around R52's waist, assisted R52 to a standing position and transferred R52 from her wheelchair to her bed while continuing to walk on R52's oxygen tubing and nasal cannula while it laid on the floor in front of her night stand. R52 proceeded to lay down in bed by herself while NA-A got a pillow case out of R52's closet for her pillow.

-At 1:27 p.m. R52 asked the NA-A about her oxygen, NA-A reached down to the floor, picked up R52's oxygen tubing and nasal cannula off the floor and handed it to R52. R52 took the oxygen tubing and applied the nasal cannula part of the tubing into both of her nostrils and wrapped the tubing around her ears independently. R52's oxygen was running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.
-At 2:12 p.m. R52 continued to lay in bed resting with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker.
-At 4:19 p.m. R52 continued to lay in bed resting with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two

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21375	Continued From page 38 liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker. During observations on 6/5/18 at 8:51 a.m. R52 was laying in bed resting with her oxygen tubing and nasal cannula applied to both of her nostrils with oxygen running at two liters per minute and the plastic green oxygen connector was dated 5/2 with a black marker. On 6/5/18 at 2:41 p.m. NA-A confirmed R52 utilized oxygen when needed and at night. NA-A confirmed the oxygen tubing and nasal cannula was lying on the floor in R52's room and she had not gotten new oxygen tubing or nasal cannula for R52 after it had been lying on the floor and walked on. NA-A indicated she was not aware that she had stepped on the tubing while it was lying on the floor and stated "I should of got a new one (tubing)." On 6/7/18 at 9:09 a.m. R52 confirmed she did get "short winded" at times and would apply her oxygen via nasal cannula. R52 indicated she utilized her oxygen when she rests, at night and indicated that it does help her. On 6/7/18 at 9:46 a.m. resident coordinator (RC)-A confirmed R52 wore oxygen when she was feeling short of breath at night and as needed during the day while resting. RC-A indicated the oxygen tubing and nasal cannula should be changed every 14 days by the licensed practical nurses and should be documented in the EMAR. The RC-A indicated she would expect staff to change R52's oxygen tubing and nasal cannula when it was found laying on the floor and staff walked on it. RC-A indicated the oxygen tubing and nasal cannula should of been changed right away.	21375		

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21375	Continued From page 39 On 6/7/18 at 3:35 p.m. director of nursing (DON) confirmed R52 wore oxygen and she would expect staff to throw the contaminated oxygen tubing away and to get a new one. Review of the facility policy titled, Oxygen Therapy revised on 3/13, indicated nasal cannula tubing and extensions will be changed every two weeks or more often if visibly soiled. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written for water borne pathogens. In addition, the DON or designee could review/revise policies on infection control regarding oxygen tubing. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: 21 (twenty-one) days.	21375		