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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CJ32

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 **06/30/2017** (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

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 :
Denise Erickson, HFE NE II 07/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/25/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
Posted 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/28/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245265 July 25, 2017

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 June 5, 2017 the above facility is recommended 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
Telephone #: Fax #:

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 25, 2017

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

RE: Project Number S5265026

Dear Mr. Nelson:

On May 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2017. 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 June 30, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 2, 2017 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 May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 5, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, effective June 5, 2017 and therefore remedies outlined in our letter to you dated May 18, 2017, 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CJ32

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(L5) **BRECKENRIDGE, MN** (L6) **56520**

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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 **05/04/2017** (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

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From (a) :
To (b) :

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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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 06/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/28/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 18, 2017

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

RE: Project Number S5265026

Dear Mr. Nelson:

On May 4, 2017, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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 a "F" 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 June 13, 2017, 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 June 13, 2017 the following remedy will be imposed:

- Per instance 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 August 4, 2017 (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 November 4, 2017 (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

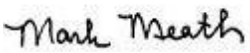
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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 related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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 _____	05/04/2017

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 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 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents reviewed (R72 and R92) were provided bathing frequency according to their preferences and customary	F 242	Staff assessed the affected residents who had concerns regarding having a bath 2x/week. Staff offered and scheduled the affected residents to take a	6/5/17

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

Electronically Signed | 05/25/2017

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 _____	05/04/2017

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 242	Continued From page 1 routines. Findings include: When interviewed on 5/1/17, at 8:17 a.m. R72 stated she received a bath once a week and would like more. R72 stated she had asked the nursing staff for more than one a week and was told she could not have more than one bath a week unless she had a physical health problem. In a follow up interview with R72 on 5/3/17, at 8:17 a.m. she indicated she used to receive two baths a week, one from the facility on Tuesdays and one on Fridays from hospice. However R72 was recently taken off of hospice care and stated, "Nobody gets two baths, they only have time for one bath per week." R72 also indicated when she asked about a second bath, staff told her she would have to have a medical reason or condition to receive another bath and stated, "I figure no use upsetting the apple cart, I can wash in the sink." R72's significant change Minimum Data Set (MDS) dated 2/15/17, indicated R72's short term and long term memory were intact, and she was independent in skills for daily decision making. The MDS included diagnoses of a stroke and depression. The MDS also indicated R72 needed physical staff assistance with bathing, however, the preferences for customary routine and activities interview had not been conducted. R72's care plan, revised on 3/21/17, indicated R72 had self care deficit related to end stage chronic obstructive pulmonary disease (COPD) and required staff assistance of one, for a.m. and p.m. partial bath, received a weekly tub bath and preferred a tub bath verses shower.	F 242	bath 2x/week. Interdisciplinary Team (IDT) will meet with resident/family on a quarterly basis to discuss resident's plan of care. Resident/family allowed to discuss satisfaction with cares, or any changes they request with plan of care. Nursing staff will start asking all residents and family members "are you satisfied with your bathing routine/schedule?" during upcoming quarterly conferences. IDT will individualize all care as appropriate for resident and per their requests. IDT also encourages residents/family to call the neighborhood staff with any concerns they would have at any time. All staff in LTC will be educated per meeting and huddle board, that if a resident requests another bath or changes in their care that is provided, staff are to alert the licensed staff and then it is to be reviewed by the charge nurse and the resident is then to be assessed for changs in their care plan. IDT will continue to meet with resident/family on a quarterly basis to discuss resident's plan of care. Nursing staff will ask residents and family members "are you satisfied with your bathing routine/scheduel?' during upcoming quarterly conferences. This question is placed on the care conference review sheet to ensure it is asked at every care conference. IDT will encourage residents/family to call or notify the neighborhood staff with any concerns they would have at any time. "Are you satisfied with your bathing routine/schedule?" will be added to the	

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 _____	05/04/2017

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 242	Continued From page 2 R72's Riverwalk CNA (certified nursing assistant) Resident Care Sheet Side A, undated, did not include a bathing schedule or choices. The facility's Bathing Sheet indicated R72 received a bath on Tuesday's during the day only. R72's, Resident Activity Log dated 2/15/17, indicated the interview for choosing between a tub bath, shower, bed bath or sponge bath had not been completed. On 5/3/17, at 7:44 a.m. registered nurse (RN)-A indicated the nursing assistants (NA) were the one who assisted residents with their baths and evening shift charge nurse talked to the residents to find out what their preferences were. The evening shift charge nurse then puts the resident on the bathing schedule according to their room number and indicated she felt the facility attempted to honor the residents wishes if requesting more than one bath a week. RN-A also indicated the staff looked at skin issues as well, to see if residents need more than one bath. In a follow up interview at 11:27 a.m. RN-A confirmed R72 had been receiving two baths a week when she was on hospice, then when hospices was discontinued, she only received one bath a week. RN-A did not recall R72 requesting a second bath. When interviewed on 5/3/17, at 7:57 a.m. NA-E stated R72 had voiced concerns about wanting more than one bath a week. NA-E stated R72's preference had been discussed at huddle meetings with the charge nurses, and, "Staff is aware she wants more than one a week." NA-E stated R72 had been taken off hospice	F 242	care conference review sheets for nursing to disucss with resident and family members during quarterly care conferences. Any plan of care change will be discussed on a quarterly or PRN basis with residents/family and documented in the residents chart. DON will attend and audit select care conferences on each neighborhood for 3 months ensuring the new process is being completed amd implemented into the care plan. This information will be shared at the Quality Assurance/ Performance Improvement Committee (QAPI). QAPI will determine if this audit needs to continue. Completion date will be June 5, 2017. Responsibility: DON	

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	245265	A. BUILDING _____ B. WING _____	05/04/2017

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 242	Continued From page 3	F 242		

approximately two months ago and had only received one bath a week since then.

When interviewed on 5/3/17, at 11:21 a.m. NA-F stated she was aware R72 had requested two baths a week, "She is the only one requesting two baths right now." NA-F indicated she had told the charge nurse when residents request more than one bath a week, and the charge nurse made the decision if two baths were provided. NA-F also indicated she felt the charge nurses were aware R72 wanted another bath a week, because they had been in huddle meetings where it had been discussed. NA-F stated R72 is currently only getting one bath a week and was getting two baths a week when she was on hospice, "a few months ago."

When interviewed on 5/4/17, at 10:50 a.m. NA-G stated R72 had requested two baths a week and verified she had received two baths a week when she was on hospice. NA-G verified R72 was currently only receiving one bath a week even though she has requested two. NA-G also stated she and other staff have brought this issue up to the charge nurses.

When interviewed on 5/4/17, at 11:24 a.m. the director of nursing (DON) indicated that on admission the activity staff does the assessment about bathing preferences, and indicated resident bathing preferences were also reviewed quarterly. The DON confirmed R72 was getting two baths a week when she was on hospice, and has been currently receiving only one a week. The DON indicated she was not aware of R72's wishes and indicated if a resident tells staff they want more than one bath a week they should notify licensed staff. The DON also indicated the facility tries to

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F 242	Continued From page 4 accommodate the residents. and verified the usual facility practice was to only give only one bath a week, unless the case was, "unusual having a health or chronic condition." The DON indicated R72 has a lot of anxiety, "So we would accommodate this to help her anxiety," and stated they should offer her two, if that is her choice. When interviewed on 5/1/17, at 4:04 p.m. R92 identified the facility staff had not asked about her bathing preference. R92 indicated she was provided one bath per week and would like to bathe more often. R92 identified prior to moving to the facility she had bathed every other day. During a follow up interview on 5/2/17, at 1:06 p.m. R92 identified she would like more than the one bath per week that she is scheduled for now. R92 identified she washed up in the bathroom this morning and washed her hair in the sink. R92 indicated she felt better now that she cleaned up and stated however,washing in the sink was not as good as getting a bath. R92 reiterated she would like more than one bath per week and questioned if other residents would like more also. R92's significant change MDS dated 4/6/17, identified R92 had intact cognition, was independent with all ADL's (activities of daily living) with the exception of needed assistance with bathing, and had a diagnosis of diabetes. The interview for daily preferences identified it was very important for R92 to choose between tub bath, shower, bed bath, or sponge bath.	F 242		

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F 242	Continued From page 5	F 242		

R92's care plan revised on 4/7/17, identified she was independent with ADL's with the exception of weekly bath/shower, directed staff to assist with bathing, and she prefers showers.

An undated facility form titled Riverwalk CNA Resident Care Sheet Side B, did not address R92's bathing schedule or choices.

The facility bathing schedule identified R92 received one bath on Wednesdays during the day shift.

When interviewed on 5/3/17, at 11:10 a.m. licensed practical nurse (LPN)-B provided a resident bathing schedule. LPN-B indicated she believed the nurse managers developed the schedule and the nursing assistants then followed the schedule.

When interviewed on 5/3/17, at 1:40 p.m. NA-B indicated the nursing assistants followed a written schedule for resident baths, Monday through Friday. NA-B stated when a resident discharged the next resident to occupy that room would be given the bath day of the previous resident. She indicated a resident may choose to have an evening bath rather than a day bath. NA-B identified the usual practice was for residents to receive one bath per week with a few residents receiving two per week. NA-B indicated residents could receive two baths per week if they ask for it, or it is needed for their hygiene.

When interviewed on 5/3/17, at 1:48 p.m. NA-D indicated the registered nurses (RN) made the decisions regarding resident baths and would have to refer to a RN if a resident had request an

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F 242	Continued From page 6 additional bath. When interviewed on 5/4/17, at 8:41 a.m. NA-A indicated a few residents received more than one bath per week but could not remember who those residents were. NA-A indicated residents could request more than one bath and if someone did she would talk to RN-B. When interviewed on 5/4/17, at 8:49 a.m. LPN-A indicated residents could request more than one bath per week but was not aware of any residents who had. LPN-A verified she was aware R92 washed her hair in the bathroom sink at times and became aware of this approximately a month ago. When interviewed on 5/4/17, at 11:13 a.m. the DON indicated the facility protocol for bathing was reviewed on admission and quarterly. The DON further stated staff ask the resident if they are meeting their needs and if the resident makes a request they would attempt to accommodate them. An undated facility policy titled Bath, Shower, indicated every resident will receive a weekly bath to cleanse and refresh the skin along with providing comfort. Additional baths will be determined by resident's need and be stated in the care plan. An undated policy titled Grooming Of Residents, included, "All residents of St Frances Home will receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being manifested in part by being fully groomed."	F 242		

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F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the facility policy for safe administration of oral medications for 4 of 4 residents (R2, R59, R49, and R32) who were administered medications which were stored in a nursing work station. Findings include: On 5/1/17, at 5:36 p.m. registered nurse (RN)-B stood in a lounge area of the facility next to a enclosed rolling cart (identified by the facility as a nursing work station). The work station had a computer monitor mounted on top with several several drawers on the front of the station. RN-B opened the top drawer of the work station and various supplies such as dressings, cough drops, and six plastic medication cups with various tablets and capsules in the cups were observed in the drawer. Each plastic cup had a first name handwritten on the outside, however lacked identification of last name, name or dose of medication in the cups. RN-B removed two	F 425	The deficient practice observed was by a nurse that is no longer employed by St. Francis. Pre-dishing medications and placing them in our nurse working station is not our standard practice. The facility RN will educate licensed staff/TMA's on correct process for medication administration per our policy. Policy/process will be reviewed in daily neighborhood huddles and written on huddle boards for 1 week. Will also review process at yearly skills day for all licensed staff and TMA's. Facility RN will audit LPN's and TMA's on both neighborhoods by monitoring the medication administration process and checking nurse work stations ensuring that there are no pre-dished medications weekly x 3 months. Licensed staff, TMA's, and work stations will be randomly audited weekly for 3 months. Audit findings will be reviewed at our QAPI quartely meeting. QAPI will determine	6/5/17

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F 425	Continued From page 8 medication cups from the drawer, one with one white tablet in it and a second with several medication tablets/capsules. RN-B placed applesauce into the cup containing the single white medication tablet and carried the medications to R2, seated at a table in the dining room. RN-B spooned the medications from the cups into R2's mouth. At 5:39 p.m. RN-B obtained another of the pre-set medications from the drawer of the work station and added apple sauce to the cup. RN-B carried the medications to the facility cafeteria where she administered the medications to R59 at 5:42 p.m. On 5/1/17, at 5:43 p.m. RN-B verified the top drawer of the work station had held six plastic medication cups with various medications RN-B had dispensed earlier for four residents. RN-B stated this was her usual practice for medication administration with the six p.m. medications for residents. RN-B stated the medications were dispensed and the first name written on the plastic cups in order to administer medications to residents during the evening meal more quickly. RN-B stated the remaining medication cups would be administered to R49 and R32 after the evening meal. On 5/3/17, at 9:06 a.m. licensed practical nurse (LPN)-B indicated the usual facility protocol was to dispense resident medications from the medications storage cabinets in each resident room and administer the medications to each resident in their room. LPN-B verified it was not the usual facility practice to pre-set resident medications in cups and place them in the nursing work station. On 5/4/17, at 8:49 a.m. LPN-A indicated she	F 425	how long audits will continue. Completion date will be June 5, 2017 Responsibility: DON	

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F 425	Continued From page 9	F 425		

would not dispense multiple residents medications into medication cups and place them together in the nurses work station. LPN-A indicated the practice could possibly lead to a medication error.

On 5/4/17, at 9:00 a.m. registered nurse (RN)-B stated resident medications should be dispensed and administered separately. RN-B indicated the practice of dispensing and storing multiple resident medications in open containers, even if labeled with the residents first name, could possibly lead to medication errors.

On 5/4/17, at 10:33 a.m. RN-A stated the facility medication administration protocol included the following: medications stored in cabinets in each residents room; staff dispense the medications to the resident in their room; occasionally for specific residents medications may be brought to the dining room for administration. RN-A indicated it was not facility protocol to dispense multiple resident medications into medication cups and place them together in a drawer of the nursing work station. RN-A stated,"It is not a storage compartment." RN-A identified this practice could possibly lead to medication errors if the staff became confused and administered the wrong medication to a resident.

On 5/4/17, at 11:13 a.m. the director of nursing (DON) indicated she felt the practice of storing dispensed medications in the nurses work station was acceptable if the plastic cup was labeled with the residents name. DON stated only one residents medications could be stored in the drawer at a time. The DON identified resident medications were stored in resident rooms in order to provide privacy and safety.

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F 425	Continued From page 10 On 5/04/2017, at 9:25 a.m. a telephone call was placed to the pharmacy consultant (PC) and a message was left, requesting a return phone call. On 5/5/17, at 9:01 a.m. via return telephone call, the facility's pharmacy consultant (PC) identified the practice of dispensing and storing multiple resident medications in the portable work station was not an acceptable practice and would be a potential to give the medication to the wrong resident. The PC identified the purpose for medication storage in each resident room was to administer the medications in the room, one resident at a time. A facility policy titled General Medication Administration Principles revised 10/12/15, included, "1. Medications will be administered in a safe and effective manor according to policy and procedure." "6. Dispensing medication in the dining room during meal time is to be minimized." The facility policy did not specifically address storage of multiple residents' dispensed medications.	F 425		

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	245265	A. BUILDING 02 - MAIN BUILDING B. WING _____	05/02/2017

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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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2017

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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	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**05/02/2017**

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K 000	Continued From page 1	K 000		

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 a manual fire alarm system with smoke detectors throughout the corridor system, in areas open to the corridors, and common areas. The Fire Alarm

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K 000	Continued From page 2 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 131 SS=D	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by:	K 131		5/3/17

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K 131	Continued From page 3 Based on observation and staff interview the facility failed to maintain the proper 3 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect an undetermined amount of staff. Findings include: On the facility tour between 8:00 am to 1:00 pm on 05/02/2017 observations and staff interview revealed a penetration in the 3 hour fire barrier above the ceiling at the railway connection. Note: The beds in this wing were not in use at this time. This deficient condition was confirmed by the Maintenance Supervisor.	K 131	This penetration was repaired by maintenance staff by installing sheetrock along with proper fire stopping material on 5-3-17. Vendors that require penetration into fire walls, will notify maintenance when they have completed their work. Maintenance staff will visually check the vendor's work to ensure that the penetration has been repaired to code. Checks will be done during environmental tours which occur every other month. At this time fire barriers will be inspected. Environmental tour information will be reviewed at Quality Assurance & Performance Improvement (QAPI) Committee. Responsibility: Steve Mann, Facility Manager	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		5/16/17

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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**

(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
K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could allow for the misinterpretation of the sprinkler systems capability to function properly and allow for the spread of fire. This could affect all of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 05/02/2017 observations, record review and staff interview revealed the sprinkler gauges were past the 5 year limit for calibration or replacement. This deficient condition was confirmed by the Maintenance Supervisor.	K 353	These gauges were all replaced on May 16 by our vendor, NOVA Fire Protection, Inc. The annual inspection reports will be double checked by the facility manager for the date the gauges need to be replaced. If this date is prior to the next 6 month inspection, Facility Manager will contact NOVA to have them replaced before that expiration date. Responsibility: Steve Mann, Facility Manager	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**05/02/2017**

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K 372	Continued From page 5 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of five smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 30 of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 05/02/2017 observations and staff interview revealed a conduit penetration without the proper fire stopping above the ceiling at the River/Prairie smoke barrier. This deficient condition was confirmed by the Maintenance Supervisor.	K 372	Conduit was plugged with approved fire stopping material by the maintenance staff on 5-3-17. Vendors that require working at smoke barriers, will notify maintenance when they have completed their work. Maintenance staff will visually check the vendor's work to ensure that the barriers have been repaired to code. Checks will be done during environmental tours which occur every other month. At this time smoke barriers will be inspected.Environmental tour information will be reviewed at Quality Assurance & Performance Improvement (QAPI) Committee. Responsibility: Steve Mann, Facility Manager	