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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: COTG

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 **04/18/2012** (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 IMR	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 **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	120			
(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):

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code. Effective March 27, 2012, the facility is certified for 120 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Pam Kerssen, Unit Supervisor — 05/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 05/10/2012 (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 5/11/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/13/2012
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5265 May 10, 2012

Mr. David Nelson, Administrator
St. Francis Home
2400 St Francis Drive
Breckenridge, Minnesota 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 March 27, 2011, the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2012

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

RE: Project Number S5265021

Dear Mr. Nelson:

On March 5, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2012. 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 April 18, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 11, 2012 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 February 16, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2012, effective March 27, 2012 and therefore remedies outlined in our letter to you dated March 5, 2012, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Pam Kerssen, Assistant Program Manager
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218)308-2129 Fax: (218)308-2122

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245265	A. Building B. Wing	4/18/2012

Name of Facility	Street Address, City, State, Zip Code
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/27/2012**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/cbl	05/10/2012	18618	04/18/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/16/2012			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245265	A. Building / B. Wing: 02 - MAIN BUILDING	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	03/27/2012	ID Prefix Reg. # NFPA 101 LSC K0072	03/27/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	05/10/2012	03006	04/11/2012
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/15/2012			

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2012

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

Re: Enclosed Reinspection Results - Project Number S5265021

Dear Mr. Nelson:

On April 18, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 18, 2012, with orders received by you on March 12, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Pam Kerssen

Pam Kerssen, Assistant Program Manager
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218)308-2129 Fax: (218)308-2122

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00818	A. Building B. Wing	4/18/2012

Name of Facility	Street Address, City, State, Zip Code
ST FRANCIS HOME	2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20550** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **04/18/2012**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **04/18/2012**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **04/18/2012**
ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **04/18/2012**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **04/18/2012**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **04/18/2012**
ID Prefix **21475** Reg. # **MN Rule 4658.1005 Subp.** LSC	Correction Completed **04/18/2012**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **04/18/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/cbl	05/10/2012	18618	04/18/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/16/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: COTG

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: **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 **02/16/2012** (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 IMR	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 **120** (L18)

13.Total Certified Beds **120** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	120			
(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):

At the time of the Standard survey, the facility was not in Substantial Compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NE II 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B, Leach, Program Specialist 04/13/2012 (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
POSTED 4/13/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5110

March 5, 2012

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

RE: Project Number S5265021

Dear Mr. Nelson:

On February 16, 2012, 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:

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

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

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

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:

Christy Johnson
Minnesota Department of Health
705 Fifth Street Northwest, Suite A
Bemidji, Minnesota 56601

Telephone: (218) 308-2114

Fax: (218) 308-2122

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 March 27, 2012, 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 March 27, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 16, 2012 (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 August 16, 2012 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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:

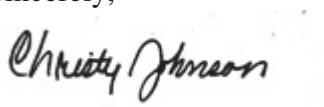
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5265s12.rtf

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 _____	02/16/2012

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	F 000		

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.

Upon receipt of an acceptable POC an 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 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	St. Francis Home will continue to report alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property immediately to the administrator/designees and to other officials in accordance with Federal and State laws. Vulnerable Adult Abuse and Neglect Reporting Policy/Procedure will be updated to meet requirements related to immediate notification of the administrator/designee and	3-27-12

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to develop appropriate policies and procedures related to the immediate notification of the administrator and the State agency and the investigation of these allegations. This practice had the potential to affect all 112 residents in the facility at the time of survey.

Findings include:

Review of several vulnerable adult reports since 9/2011, revealed the facility had reported and investigated the incidents/allegations timely. However, the facility's policy and procedures related to reporting and investigating allegations

Continued 4/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President/CEO	3-21-12

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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F 226	Continued From page 1	F 226		

of abuse, neglect, and mistreatment lacked required components.

The Vulnerable Adult/Child Abuse and Neglect Reporting policy dated 4/2006, with excepts updated in 9/2011, identified staff were not directed to notify the administrator and State agency immediately of all allegations of abuse, neglect and mistreatment. The following excerpts indicated:

"..Any person employed by St. Francis Healthcare Campus who identifies a situation involving maltreatment will immediately report the variance to the Social Worker for that facility."

"The Social Worker/designee uses the form (variance form) to investigate, If immediate action is not needed, investigation can be done by the social Work when on duty. Must be reported to Common Entry Point within 24 hours."

"Administration/vice President of Nursing Services or the Administrative person on call is notified prior to external reporting, but no longer than 24 hours."

"After collaboration with the person who identified the vulnerable situation, the Social Worker/Designee will decided whether the variance is reportable to the common entry point."

"If abuse or neglect is identified, the Supervisor is to discuss stat with their immediate Supervisor."

"Hand deliver completed report to Social Worker or designee immediately."

the State Agency by March 23, 2012. The revised policy/procedure will be reviewed at the licensed staff meetings on March 23 and March 26. To make sure the policy/procedure stays current, the MDH and CMS websites will be checked monthly for any changes related to mistreatment, neglect, and abuse of residents and misappropriation of resident property. Any law changes that affect this policy/procedure will be done on a timely basis and all staff will be made aware of changes through inservicing. QA&A will have a standing agenda item to include CMS/MDH changes for reporting purposes.

Responsible: VP of Healthcare Services.

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F 226	Continued From page 2	F 226		

The Reporting Procedure directed the facility staff to report to the social services instead of the facility administrator and the State agency.

"If indications of abuse are found, the Director of Nursing and/or Administrator/designee must be notified."

"Investigation must be documented and all findings reported in writing to the Administrator/designee as soon as possible, but no later than 24 hours following the alleged incident."

"Verbal or physical aggression occurring between patients, resident, or clients of a facility, or self abuse behavior by these person doe not constitute abuse unless the behavior causes serious harm."

At 3:58 p.m. on 2/14/12, licensed social worker (LSW)-B reviewed the abuse policy and verified the policy did not direct the staff to notify the administrator or the State agency immediately. She stated the facility had a system in which the administrator had established an on call system. However, the facility policy did not include which administrative staff members had the authority to act as the administrator in the time of his absence.

At 11:45 a.m. on 2/15/12, the administrator stated members of the senior leadership had the authority to act as the administrator in his absence. The members included the human service director, the chief financial officer, the director of mission, the vice president of health services and himself . He stated he was the

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F 226	Continued From page 3 person on call Monday - Friday but on weekends or during times of his absence, the other identified staff members had full authority to address any concerns related to abuse and neglect. He stated the facility utilized the on call system, but verified this authority had not been developed into a written policy. At 3:02 p.m. on 2/15/12, LSW-A reviewed the facility policy. She stated during the summer of 2011, the facility had worked on their abuse and neglect policy and reporting system. She stated the facility had made operational adjustments which included informing the facility administrator and the State agency of any alleged abuse and neglect situations immediately. She verified the current written policy had not been fully updated to direct the staff to immediately report the allegations to the administrator and the State agency immediately. At 10:00 a.m. on 2/16/12, LSW-A provided a copy of an email dated 12/15/11, in which the facility had identified several areas of the vulnerable adult policy which they felt were in need of changing. This included some of the identified areas as noted prior. LSW-A stated she had sent the email to other members of the facility staff, but they had not had a chance to meet and rewrite the policy. She verified the policy was in need of revision.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	St. Francis Home will continue to provide medically-related social services to attain or	3-27-12

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F 250	Continued From page 4	F 250		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to assure that sufficient and appropriate social services interventions were provided for 1 of 1 resident (R32) who exhibited wandering behaviors.

Findings include:

R32's diagnoses included depression and dementia. The quarterly Minimum Data Set (MDS) dated 11/28/11, identified R32 with cognitive impairments and as requiring extensive assistance with all activities of daily living. The MDS also revealed R32 had difficulty concentrating, became easily annoyed with others, and displayed wandering behaviors that intruded on the privacy of others.

The clinical record lacked a comprehensive assessment of the wandering behaviors including: when the behaviors occurred, interventions to decrease the behaviors, and an evaluation of the behaviors.

The current plan of care printed on 2/16/12, identified R32 as having delusional thinking and exhibiting behaviors such as wandering and combativeness with cares. The care plan interventions identified R32's medications for behaviors that included Seroquel (antipsychotic medication). However, the care plan lacked non-pharmacological interventions to be implemented when R32 displayed the behaviors.

maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A comprehensive interdisciplinary wandering assessment policy and procedure was developed on 3-19-12. The wandering assessment policy and procedure will be reviewed at the licensed staff meetings on March 23 and 26, 2012. Quality assurance monitoring put into place and will be completed by Social Services. QA&A Committee to monitor results.

Responsible: DON

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F 250	Continued From page 5	F 250		

Review of the Mood and Behavior documentation from 12/18/11 - 2/15/12, revealed R32 had 14 separate incidents of wandering behaviors.

The behavior notes dated 1/2/12, indicated R32 wandered in the evenings and was difficult to redirect. A note dated 1/17/12, indicated R32 had been wandering into other resident rooms and had been difficult to redirect. A note dated 2/7/12, indicated R32 had required assistance to leave another resident's room.

Review of the social service notes identified documentation related to R32's behaviors in the past year was lacking.

At 4:40 p.m. on 2/13/12, R46 reported R32 would occasionally wander into her room without permission. She stated R32 would take items and it bothered her when R32 would come into her room. She also reported R32 would become loud during meals and during the noon meal on 2/13/12, she had to leave the dining room because of R32's behaviors were making her upset.

At 6:00 p.m. on 2/13/12, R32 was observed to eat her evening meal in the dining room without incident.

At 7:30 p.m. on 2/13/12, R32 was observed in a wheelchair wandering on the Prairie Meadows Neighborhood. She was observed to independently wheel herself down the hallway and look out the exit door. She was not observed to go into any other resident's room.

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F 250	Continued From page 6	F 250		

At 9:32 a.m. on 2/14/12, R95 reported R32 would wander into his room and take items without his permission. He stated the staff members were aware that R32 wandered into other residents' rooms.

At 10:00 a.m. on 2/14/12, R105's family member (FM-1) stated R32 would occasionally wander into 105's room which was upsetting to R105. She stated the facility staff members were aware of the wandering behaviors.

At 1:30 p.m. on 2/15/12, registered nurse (RN)-B stated R32 would wander into other resident rooms and would take the personal items from the rooms. She stated when the staff notice R32 in another resident room, they are to assist her out of the room. She stated R32 was very difficult to redirect at time. She stated she was unaware other residents on the unit were bothered by R32's behavior and was not aware of any family concerns related to R32's behaviors. At that time, she reviewed R32's record and verified the record did not contain a comprehensive assessment of the wandering behaviors.

At 1:52 p.m. on 2/15/12, quality of life aide-A stated she was aware R32 would wander into other resident rooms, but stated she was not aware of the behavior bothering any of the other residents. She stated she would at times attempt to engage the resident in an activity when she was wandering, but it didn't always work.

At 2:03 p.m. on 2/15/12, nursing assistant (NA)-O stated he had been working during the noon meal on 2/13/12. He stated R32 had an episode of

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F 250	Continued From page 7 being very loud in the dining room and R46 became upset and nervous because of her behaviors and left the dining room. He stated R46 ate her meal in her room because of R32's behaviors. At 2:30 p.m. on 2/16/12, licensed social worker (LSW)-A stated she was aware of R32's wandering behaviors, including behaviors in which she wandered into other resident rooms. She stated some other residents had made concerns related to a resident's wandering behaviors, but she had not investigated the concerns to determine which resident was displaying the behavior to ensure appropriate interventions were in place to decrease the behaviors. She verified she had not completed a comprehensive behavior assessment of R32's behaviors.	F 250		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to assess wandering behaviors for 1 of 1 resident (R32) identified with wandering behaviors. Findings include: R32's diagnoses included depression and	F 276	St. Francis Home will continue to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A comprehensive interdisciplinary wandering assessment policy and procedure was developed on 3-19-12. The wandering	3-27-12

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F 276	Continued From page 8	F 276	assessment policy and procedure will be reviewed at the licensed staff meetings on March 23 and 26, 2012. Quality assurance monitoring is put into place and will be completed by Social Services. QA&A Committee to monitor results. Responsible: DON	

dementia. The quarterly Minimum Data Set (MDS) dated 11/28/11, identified R32 with cognitive impairments and as requiring extensive assistance with all activities of daily living. The MDS also revealed R32 had difficulty concentrating, became easily annoyed with others, and displayed wandering behaviors that intruded on the privacy of others.

The clinical record lacked a comprehensive assessment of the wandering behaviors including: when the behaviors occurred, interventions to decrease the behaviors, and an evaluation of the behaviors.

At 1:30 p.m. on 2/15/12, registered nurse (RN)-B stated R32 would wander into other resident rooms and would take the personal items from the rooms. She stated when the staff notice R32 in another resident room, they are to assist her out of the room. She stated R32 was very difficult to redirect at time. She stated she was unaware other residents on the unit were bothered by R32's behavior and was not aware of any family concerns related to R32's behaviors. At that time, she reviewed R32's record and verified the record did not contain a comprehensive assessment of the wandering behaviors.

At 1:52 p.m. on 2/15/12, quality of life aide-A stated she was aware R32 would wander into other resident rooms, but stated she was not aware of the behavior bothering any of the other residents. She stated she would at times attempt to engage the resident in an activity when she was wandering, but it didn't always work.

At 2:30 p.m. on 2/16/12, licensed social worker

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F 276	Continued From page 9	F 276		

(LSW)-A stated she was aware of R32's wandering behaviors, including behaviors in which she wandered into other resident rooms. She stated some other residents had made concerns related to a resident's wandering behaviors, but she had not investigated the concerns to determine which resident was displaying the behavior to ensure appropriate interventions were in place to decrease the behaviors. She verified she had not completed a comprehensive behavior assessment of R32's behaviors.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, interview and document review, the facility failed to provide timely assistance with repositioning and toileting according to the plan of care for 1 of 2 (R88) residents in the sample who required assistance.

Findings include:

R88 was not provided assistance with toileting or repositioning according to the plan of care (POC).

The POC dated 1/29/09, indicated R88 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to reposition every 2 hours, and check for

F 282

St. Francis Home will continue to ensure that services provided will be provided by qualified persons in accordance with each resident's written plan of care. The resident care sheets that all NA-R's carry have been updated to include residents that have pressure ulcers and the priority of every 2 hour repositioning. The nursing staff will also carry the resident care sheet to assist in reminding NA-R's regarding importance of repositioning with pressure ulcers. This new practice to be reviewed at the licensed staff meeting on 3-23&26, 2012 and on3-21-12 at the NA-R

3-27-12

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F 282	Continued From page 10 incontinence every 2 hours. On 2/15/12, R88 was observed from 7:30 a.m. to 10:00 a.m. (2.5 hours) to be positioned on her right side in bed and was not provided assistance with repositioning or toileting. Nursing Assistant (NA)-H verified findings. On 2/16/12, R88 was observed from 7:30 a.m. to 10:30 a.m. (3 hours) to be positioned in her wheelchair and was not provided assistance with reposition or toileting. R88 was observed to be saturated with urine (thorough clothes). NA-H verified findings.	F 282	meeting. Quality assurance monitoring put into place and will be completed by licensed staff. QA&A Committee to monitor results. Responsible: DON	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide appropriate treatment to promote healing of pressure ulcers for 1 of 1 (R88) residents in the sample with pressure ulcers. Findings include:	F 314	St. Francis Home will continue to ensure that services provided will be provided by qualified persons in accordance with each resident's written plan of care. The resident care sheets that all NA-R's carry have been updated to include residents that have pressure ulcers and the priority of every 2 hour repositioning. The nursing staff will also carry the resident care sheet to assist in reminding NA-R's regarding importance of repositioning with pressure ulcers. This new practice to be reviewed at the licensed staff	3-27-12

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(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 314	Continued From page 11	F 314	meetings on 3-23&26, 2012 and at the NA-R meeting on 3-21-12. Quality assurance monitoring put into place and will be completed by licensed staff. QA&A Committee to monitor results. Responsible: DON	

R88 who had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open area usually over a bony prominence) was not provided timely assistance with repositioning and dressings were not applied according to plan of care.

The Full Minimum Data Set (MDS) completed on 10/31/11, indicated R88 required extensive to total assistance with all activities of daily living (ADLs), was at risk for development of pressure ulcers and had severe cognitive impairment. The quarterly MDS completed on 12/30/11. indicated the same as the previous MDS. The plan of care (POC) dated 1/29/09, indicated R88 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to monitor for redness, keep clean and dry, pressure relieving devices in wheelchair and bed, and to reposition every 2 hours.

The nursing progress notes indicated:

2/12/12- Quick Note - Dr. (name) notified of open area and treatment to the left buttock
2/12/12 Treatment Orders - Monitor Stage II PU to coccyx, daily at 0800. D/C (discontinue) when healed.

The Skin and Wound Flow Sheet indicated:

2/9/12- open lesion to coccyx. 1 cm by 2 cm. Duoderm (dressing for treatment of pressure ulcers) applied. Arginaid added for healing.
2/11/12- Measurement same
2/14/12- 1 cm by 1 cm. Using NCC (barrier

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cream).

The Temporary Care Plan dated 2/9/12 indicated:

Stage II PU - Duoderm q (every) 7 days as needed (prn).
Repo every 2 hours.
Follow skin/wound guidelines.

Treatment orders:
2/11/12 - chart s/w (size/width) stage II PU to coccyx every Tuesday - monitor stage II PU.
2/10/12 - Vit C

A Tissue Tolerance Testing form (used to assess appropriate repositioning schedules) dated 2/11/12 for w/c documented R88 had a stage 2 PU to the inner left buttocks and was able to tolerate an every 2 hour repositioning schedule. Refer to skin risk assessment. Add Roho cushion to POC. A Tissue Tolerance Testing form dated 2/10/12 for bed also indicated an every 2 hour repositioning schedule.

A Braden Scale (tool for predicting pressure ulcer risk) dated 2/11/12, documented a score of 12 which would indicate high risk.

On 2/15/12 at 7:30 a.m. R88 was observed in bed lying on her right side. R88 was observed to remain positioned on her right side in bed until 10:00 a.m. when Nursing Assistant (NA)-H went into her room to provide morning cares. NA-H stated the last time R88 was checked for incontinence or repositioned was at approximately 7:30 a.m.. NA-H added usually R88 gets up earlier but "other priorities prevented that today." Perineal care was provided and a

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stage 2 pressure ulcer (PU) was observed to the left of the coccyx area measuring approximately 1 cm. There was no dressing to the PU. The PU was red in color and shallow. NA-H stated the PU was new and she applies cream after cares. She added the Duoderm dressing does not work well on the coccyx as bowel movement (BM) gets under it. R88 was transferred to her wheelchair (w/c) and a Roho cushion was observed in the seat of w/c.

On 2/16/12 at 7:30 a.m. R88 was observed up in the w/c in the dining room. She was served breakfast at 8:15 a.m.. At 9:20 a.m. she was wheeled to a seating area at the end of the hall.

On 2/16/12 at 9:00 a.m. licensed practical nurse (LPN)-C was questioned about the treatment for the PU and she stated she was not sure if Duoderm was on or not as she had not checked it. She added the nursing assistants will usually tell her if it has fallen off.
The electronic medication administration record (MAR) was reviewed with LPN-C and did not include the treatment to check the Duoderm to the PU.

At 10:20 a.m. NA-H was questioned about R88's repositioning schedule. She stated she has not gotten to R88 yet and she had to help another resident first. NA-H added that the nurse wanted to check her PU and put Duoderm on.

At 10:30 a.m. a nursing assistant was observed to wheel R88 to her room. LPN-C was also in the room. R88 was transferred into bed via hoyer lift.

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F 314	Continued From page 14 Following perineal care, LPN-C cleansed the PU and applied thin Duoderm to the area. NA-H verified at that time R88 had not been assisted with repositioning since she was gotten out of bed around 7:30 a.m. (3 hours later) and she should be repositioned every 2 hours. At 10:40 a.m. the Unit Manager (RN-A) was interviewed. She verified the plan of care was not followed and R88 should have been repositioned every 2 hours. RN-A checked the electronic MAR and verified it did not contain a treatment order to check Duoderm on coccyx.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence care for 1 of 2 (R88) residents in the sample with incontinence. Findings include: R88 was not provided timely assistance with	F 315	St. Francis Home will continue to ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent UTI's and to restore as much normal bladder function as possible. St. Francis Home will continue to ensure that services provided will be provided by qualified persons in accordance with each resident's written plan of care. The resident care sheets that all NA-R's carry have been updated to include residents that have pressure ulcers and the priority of	3-27-12

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incontinence care on 2/15/12 and 2/16/12.

The Full Minimum Data Set (MDS) completed on 10/31/11, indicated R88 required extensive to total assistance with all activities of daily living (ADLs), was frequently incontinent of urine, and had severe cognitive impairment.
The quarterly MDS completed on 12/30/11, indicated R88 was always incontinent or urine due to progression of Alzheimer's disease. The plan of care dated 1/21/09, indicated R88 required assistance with ADLs due to Alzheimer's disease and to check pad for incontinence every 2 hours and as needed.

The Bowel and Bladder Assessment dated 10/8/11, updated 12/29/11, indicated R88 had functional incontinence and was on a check and change program every 2 hours.

On 2/15/12 at 7:30 a.m. R88 was observed in bed lying on her right side. R88 was observed to remain positioned on her right side in bed until 10:00 a.m. when Nursing Assistant (NA)-H went into her room to provide morning cares. The NA-H stated the last time R88 was checked for incontinence was at approximately 7:30 a.m.. NA-H added usually R88 gets up earlier but "other priorities prevented that today." Perineal care was provided and R88 had been incontinent of urine.

On 2/16/12 at 7:30 a.m. R88 was observed up in the w/c in the dining room. She was served breakfast at 8:15 a.m.. At 9:20 a.m. she was wheeled to a seating area at the end of the hall.

every 2 hour repositioning. The nursing staff will also carry the resident care sheet to assist in reminding NA-R's regarding importance of repositioning with pressure ulcers. This new practice to be reviewed at the licensed staff meetings on 3-23&26, 2012 and at the NA-R meeting on 3-21-12. Quality assurance monitoring put into place and will be completed by licensed staff. QA&A Committee to monitor results.

Responsible: DON

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F 315	Continued From page 16 At 10:20 a.m. NA-H was questioned about R88's toileting schedule. She stated she has not gotten to R88 yet and she had to help another resident first. At 10:30 a.m. a nursing assistant was observed to wheel R88 to her room. R88 was transferred into bed via hoyer lift. R88's brief was saturated with urine which had leaked through her pants. NA-H verified at that time R88 had not been assisted with toileting since she was gotten out of bed around 7:30 a.m. (3 hours later) and she should be checked every 2 hours. At 10:40 a.m. the Unit Manager (RN-A) was interviewed. She verified the plan of care was not followed and R88 should have been checked for incontinence every 2 hours.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an environment free of potential accident hazards in the sitting areas on 2 of 3 neighborhoods (Railways and Prairie Meadows) in which electric fireplaces were in use. This	F 323	St. Francis Home will ensure that the resident environment remains as free of accident hazards as is possible. The power sources for all 6 fireplaces in the neighborhood parlors were disconnected and all the switches were tagged as "no longer in service" on 2-16-12. A statement has been placed in the Fire Marshal Regulatory Compliance book stating the fireplaces have	3-27-12

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F 323	Continued From page 17	F 323	been permanently disabled and not to be activated. Random checks will be done to assure fire places have not been activated. QA&A Committee to monitor results. Responsible: Plant Operations Director	

practice had the potential to affect only the independently mobile residents on these units.

Findings include:

Railways unit

Northern Pacific Line/Milwaukee Road Line and Wild Rice River/Red River of the North fireplaces

On 2/13/12, at 7:13 p.m. the fireplace located within the lounge between Northern Pacific Line and Milwaukee Road Line, within the Railways unit did not appear to be on as no flame was present. However, along the upper black ventilation grill the fireplace felt very hot to the touch. No residents were present in the lounge at that time.

At 7:36 p.m. this fireplace remained the same, no residents were present in the lounge.

On 2/14/12, at 8:30 a.m. the fireplace again appeared to be off as no flame was present, yet the upper black ventilation grill along the top of the fireplace was very hot to touch. No residents were in the lounge area.

At 10:00 a.m. the fireplace remained very hot to touch along the upper black ventilation grill. Four residents in wheelchairs were in the lounge area at that time, the closest resident was approximately 8 feet from the fireplace. None of the residents attempted to propel their wheelchairs.

At 11:30 a.m. no residents were in the lounge at this time. The fireplace ventilation grill remained

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very hot at this time.

On 2/14/12, at 2:24 p.m. nursing assistant (NA)-A stated she had never seen the fireplaces on. When shown that the fireplace did not look on, yet was hot to touch along the ventilation grill, NA-A stated she had never noticed that before. NA-A stated she guessed maintenance would turn on the fireplaces, and was not aware of any thermometers used by the fireplaces to monitor the temperature. NA-A stated no residents had ever touched the fireplace and no one had ever sustained a burn that she knew of.

On 2/14/12, at 2:27 p.m. NA-B stated the fireplace "hasn't been used this winter." NA-B was brought to the fireplace and verified it was hot to touch. NA-B stated there was no way to monitor the fireplace temperature. NA-B stated, "We wouldn't even know it was on." NA-B stated no residents had touched the fireplace and no one had ever been burned.

On 2/14/12, at 2:31 p.m. NA-C stated she had never seen the fireplace on. NA-C stated she had never seen residents feel the fireplace and no one had been burned.

On 2/14/12, at 2:34 p.m. the director of plant operations (DPO) checked the fireplace in the lounge between Wild Rice River and Red River of the North. At that time, the DPO stated, "They are terribly hot." The DPO stated they would be disconnected right now and added they would put up signs that said: do not use.

On 2/15/12, at approximately 8:30 a.m. and on 2/16/12, at 8:30 a.m. the fireplace on the Railway

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unit between the Northern Pacific Line and the Milwaukee Road Line was observed to not feel hot.

On 2/16/12, at 9:05 a.m. the unit clerk (UC)-A verified there were 19 residents on these areas affected.

Soo Line/Great Northern Line fireplace

On 2/13/12, at 7:20 p.m. an electric fireplace between the Soo Line hall and the Great Northern Line hall located on the Railways Neighborhood was observed to be on. The fireplace was approximately 3 feet high by 3 feet wide and 1 foot deep. It had a chain linked screen covering the front of it. The fireplace surround was framed with a 2 inch black metal strip. The surveyor touched the black metal strip which was extremely hot to the touch (could not touch for greater than 1 second.) 1 resident was sitting approximately 15 feet from the fireplace and another resident was sitting further away in a reclining chair.

At 8:30 a.m. on 2/14/12, this fireplace was observed to be on. There were no residents in the area as they were eating breakfast. At 9:21 a.m. the fireplace remained on and was extremely hot to the touch. One resident was sitting in a wheelchair approximately 5 feet from the fireplace. At 10:33 a.m. the fireplace remained extremely hot to the touch. Six residents were seated approximately 4 feet from the fireplace, however, none of the residents were observed to be wandering near the fireplace.

At 2:24 p.m. on 2/14/12, NA-E, NA-H, and NA-F

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stated they had never turned on the fireplace and were not sure how it worked. They added they had not seen any residents get close to the fireplace. At this same time, NA-G stated she had noticed the fireplace running on Sunday morning 2/12/12, and had thought it had been fixed and working again.

The director of plant operations (DPO) was interviewed at 2:11 p.m. on 2/14/12, and stated, the staff turned the fireplaces on and off, and he thought they were remote controlled. The DPO added, "I don't really know much about those, they are supposed to check and make sure they are turned off every evening." The DPO added there was not a way to monitor the fireplaces surface temperatures. The DPO stated the maintenance department did not have a policy or a standard preventative maintenance program for the monitoring of the fireplaces, but added he thought the nursing department may have one.

On 2/14/12, at 2:38 p.m. registered nurse (RN) Quality and Clinical Financial Coordinator confirmed the nursing department did not have a policy on the use and monitoring of the neighborhood fireplaces.

At 2:24 p.m. on 2/14/12, the DPO tested the Railways sides A and B fireplaces. The mantel on Railways A measured 178 degrees Fahrenheit, and the mantel on Railways B measured 168 degrees Fahrenheit. The DPO verified that these measurements were not safe and immediately turned both fireplaces off by pulling out the switches that connected to the heat source. The DPO further added, "We did not know they were that hot."

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Prairie Meadows unit

On 2/13/12, at 5:00 p.m. the Prairie Meadow fireplaces were observed to be off.

On 2/14/12, at 3:24 p.m. NA-L and NA-M stated they could not recall the last time the fireplaces on the Prairie Meadow neighborhood had been on and were unsure how to turn on the fire places.

On 2/13/12, at 2:27 p.m. NA-N stated the fireplaces had been on during the Christmas season but was unsure how to turn it one.

On 2/14/12, at 2:30 p.m. RN-B stated the fireplaces on the Prairie Meadow Neighborhood were not used. She stated the fireplaces were equipped with a control panel behind the metal enclosure on the bottom of the fireplace which turned the fireplaces on and off.

On 2/15/12, at 9:05 a.m. the maintenance director stated he had removed the main knobs from the fireplaces so they were inoperable.

F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	St. Francis Home's Nurse Staff Information will be posted with the required information and at a height that residents can view it by the Staff Coordinator Monday through Friday. On the weekends, the Charge Nurse	3-27-12

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- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.

o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to post the required nurse staffing information with the correct date and at a height that residents could view it. This practice had the potential to affect all 112 residents residing in the facility.

Findings include:

During the initial tour at 12:45 p.m. on 2/13/12, the nurse staffing hours were posted on a bulletin board next to the Social Service Department. The nurse staffing posting was dated for 2/10/12.

will be responsible for posting the required staffing forms. This new process was implemented on 2-18-12. Quality assurance monitoring put in place and will be completed by licensed staff. QA&A Committee to monitor results.

Responsible: DON

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F 356	Continued From page 23 (Friday) and at a height where residents could not view it. The Nursing Staff Hours Policy dated 1/12, indicated the nursing staff hours were to be posted at 10:00 a.m. daily by the staffing coordinator "except on Friday, Saturday, and Sunday will also be posted related to the fact that Staffing Coordinator works M-F." An interview with the Staffing Coordinator at 8:30 a.m. on 2/16/12, verified the nurse staffing hours were incorrect and placed too high for residents to view. She stated it was her responsibility to post the nurse staffing information by 10:00 a.m. daily. She also stated the nurse staffing hours for Saturday and Sunday were placed behind Fridays hours, however, there was no staff assigned to post the nurse staffing information for the weekends.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 371	St. Francis Home will continue to store, prepare, distribute and serve food under sanitary conditions. Education was provided on 2-22-12 to FNS staff, 3-7-12 to licensed staff and will be provided to NA-R's on 3-21-12 regarding washing hands before and after contact with residents and proper gloving technique which will include	3-27-12

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	245265	A. BUILDING _____ B. WING _____	02/16/2012

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 371 Continued From page 24

review, the facility failed to ensure staff served foods in a sanitary manner related to appropriate hand hygiene prior to touching food items during the distribution of food in 3 of 3 dining rooms (Lady Slipper, Wild Flower, Railways). This practice had the potential to affect all 112 residents residing in the facility.

Findings include:

Lady Slipper/Wild Flower

At 5:35 p.m. on 2/13/12, the Prairie Meadows unit was observed to have two dining rooms. The first dining room, Lady Slipper had 15 residents sitting in it. The second dining room, Wild Flower, had 14 residents waiting for their meal.

At 5:45 p.m. cook-B donned gloves and began dishing plates for the residents in the Lady Slipper dining room. As she dished the meals, she reached directly into the steam table with her gloved hand and picked up baked potatoes for residents. She also reached into the container of dinner rolls and picked up a the dinner roll with her gloves hand.

At 5:50 p.m. cook-B flipped through the dietary cards located in a flip folder (kardex) resting on a counter next to the steam table. Cook-B then returned to the steam table wearing the same gloves and again began dishing up the meals for the residents. She was observed to directly touch the dinner rolls and the baked potatoes with the same gloved hands.

At 5:52 p.m. the dietary staff completed dishing the meals for the 15 residents and 3 room trays

F 371

cross-contamination. Random observations will be conducted by Infection Control Nurse or designees. Data will be shared at monthly FNS, NA-R and licensed staff meetings and quarterly at QA&A. QA&A Committee to monitor results.

Responsible: DON

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for the Lady Slipper dining room. Cook-B and dietary aide (DA)-C then wheeled the steam table and the meal cart to the Wild Flower dining area. Cook-B and DA-C did not remove their gloves when they moved the carts and the electrical cords for the steam table.

At 5:54 p.m. cook-B began dishing the meals for the residents in the Wild Flower dining room. She continued to wear the same gloves as she picked up the baked potatoes and the dinner rolls with her gloved hand. At 6:00 p.m. all 14 residents in the Wild Flower dining room received their evening meal. The dietary staff did not change their gloves during the entire meal service observed.

At 8:40 a.m. on 2/15/12, the breakfast meal was observed in the Lady Slipper dining room. The breakfast meal was an open breakfast in which the staff members would prepare the meals for the residents.

At 8:41 a.m. nursing assistant (NA)-J began preparing a meal for a resident. She donned gloves and placed bread into a toaster. She touched the toaster with her gloved hand. She then went to the freezer and removed a zip lock bag of sausages, opened the bag, and then removed three sausages. She then placed the sausages on a plate, opened the microwave, closed the door, started the microwave and replaced the bag back in the freezer. She then opened a drawer, removed a small bowl and filled it with fruit. She placed the fruit cup on a tray and then went to a small steam table and removed a boiled eggs from the container and proceeded to peel the egg. She placed the pealed egg on a

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F 371	Continued From page 26	F 371		

plate, removed the bread from the toaster, buttered it, and removed the sausages from the microwave. She arranged each of the items on the resident's plate touching the food with her gloved hands. At 8:43 p.m. she removed her gloves, picked up the tray and delivered it to a resident on the unit.

At 8:44 a.m. NA-K donned a glove on her left hand and placed a slice of bread into the toaster. She then donned a second glove, reached into the steam table and removed a boiled egged, pealed the egg and placed it on a plate. She then opened a drawer, removed a small bowl, filled it with mixed fruit. At 8:45 a.m. she removed the toast from the toaster, buttered it, placed it on the plate and cut the egg with the same gloved hand. She then delivered the meal to a resident in the dining room.

At 9:09 a.m. NA-K donned gloves prior to placing bead in the toaster. She kept her gloves on as she walked over to a resident sitting at the kitchen counter. She talked to the resident, touched the resident's hand and the counter. She then returned to the toaster and removed the bread with her same gloved hands. After adding butter and jelly to the toast, she delivered it to another resident in the dining room. She was observed to remove her gloves after she had delivered the toast to the resident in the dining room.

Railways

During meal observation in the Railways dining room at 5:00 p.m. on 2/13/12, 16 residents were being served supper. DA-B donned a pair of

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gloves without washing her hands first. DA-B took 2 pieces of bread from the bread bag and placed them into the toaster. While the bread was toasting, DA-B opened the upper cupboard and took out a plate, she then opened the silverware drawer and took out a knife. With the same gloved hands DA-B removed the bread from the toaster and proceeded to butter it and then brought it to a resident. DA-B did not wash or sanitize her hands during any of the observed meal service.

During observation of the same meal at approximately 5:13 p.m. NA-I was observed wearing gloves. NA-I was assisting the residents with buttering their dinner rolls and applying butter to their baked potatoes. NA-I dropped a pat of butter on the floor, picked it up with the same gloved hands and placed it on the table and continued to assist the residents with buttering their rolls and potatoes. NA-I did not remove her contaminated gloves or sanitize her hands after picking up the butter pat from the floor.

On 2/15/12, at 11:27 a.m. on the Railways unit. DA-A donned gloves, but was not observed to wash hands or use hand sanitizer prior to serving baked beans to residents.

At 11:33 a.m. cook-A touched a piece of paper on the steam table with her gloved hand, then used the same gloved hand to scoop steak fries and handle buns. Cook-A continued to handle steak fries and buns with the same gloved hand until all 19 residents on that unit were served.

At 11:48 a.m. cook-A stated, "I don't use tongs to

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F 371	Continued From page 28 handle the buns or fries generally." She stated she used gloved hands instead of tongs or utensils because it was easier to get the buns open and get the right serving size of the fries. On 2/15/12, at 12:20 p.m. the director of food and nutritional services (DFNS), stated staff should have either used hand sanitizer or washed hands prior to serving resident foods. The DFNS verified after cook-A touched the paper on the steam cart, she should have either washed her hands or used hand sanitizer and changed her gloves prior to serving more food. The DFNS stated the policy directs for staff to use gloves to touch food the resident is going to eat. The DFNS added if staff have touched cabinets or other dirty surfaces, they need to remove those gloves, and either wash or use hand rub, then reapply a glove to handle food. The facility policy titled Hand Hygiene reviewed 5/10, directed staff to wash hands before donning gloves, after removing gloves, and after contact with objects and equipment in the resident's immediate vicinity.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	St. Francis Home will continue to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. All licensed nurses attended skills lab on March 6, 7, 13 and 14, 2012	3-27-12

QA&A Committee to monitor results.

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in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure proper hand washing while providing care for 1 of 4 (R88) residents in the sample observed to receive cares.

Findings include:

which covered wound care and infection control. This topic will be discussed again at the licensed staff meetings on 3-23&26, 2012. NA-R's will have infection control training on 3-21-12. Quality assurance monitoring put into place and will be completed by the Infection Control Nurse. Data will be shared at monthly NA-R and licensed staff meetings. Data will also be reported at QA&A. QA&A Committee to monitor results.

Responsible: DON

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Staff failed to change gloves and/or wash hands prior to providing pressure ulcer cares for R88.

On 2/16/12, at 10:30 a.m. a nursing assistant was observed to wheel R88 to her room Licensed practical nurse (LPN)-C was also in the room. R88 was transferred into bed via hoyer lift. R88's brief was saturated with urine. LPN-C applied gloves and proceeded to assist with removing the brief and providing perineal care. She then cleansed the pressure ulcer. Without removing her gloves, LPN-C then proceeded to pick up the Duoderm (dressing for treatment of pressure ulcers) package (had pre-cut pieces) and then used the soaker pad under R88 to pat dry the coccyx area. LPN-C applied the Duoderm over the pressure ulcer with the contaminated gloves. With the same gloved hands LPN-C grabbed a roll of garbage bags from the resident's drawer and passed them to the nursing assistant. She then removed her gloves and without washing her hands proceeded to adjust clothing, bedding and the hoyer sling. At that point LPN-C used alcohol based foam to disinfect her hands prior to leaving the room. She verified after the observation that she should have changed gloves prior to applying the Duoderm.

The Handwashing Policy dated 2/12, indicated the following: Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn, and immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel and/or the environment. Some examples, but not limited to: ... before

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F 441	Continued From page 31 touching wounds of any kind, ... after touching any item or surface that may have been contaminated.	F 441		

4/2/2012
Updated POC for St. Francis Home Survey 2/16/12

F- 282/314/315
For resident R-88 pressure ulcer healed 2/20/12.
R-88 was identified as high priority/pressure ulcer on resident care sheet that nurse aide and licensed staff carry. This will identify repositioning and toileting schedules.
Current and new residents will have Braden score reviewed to identify high risk skin issues and identified on resident care sheet as priorities for repositioning. Will then be discussed by IDT resident care team at a weekly meeting.

F-250/276
For resident 32 a comprehensive wandering assessment was completed by social services and individualized interventions were placed in R 32's care plan by social services and nursing.
For current and new residents identify wandering behavior through the MDS section E and discussion with nurse aides and licensed staff on resident observations. This information will be shared at the IDT resident care team at a weekly meeting.
Wandering assessment policy and procedure will be reviewed at licensed nurses on April 4th 2012. (Dated changed from previous POC of March 23rd and 26th)
→ this is additional education per phone call — 4/2/12 @ 3:05 pm
POC date remains 3/27/12 ef
Becky Johnson DNS
Mary Helland VP of Health Care Services

F526502I

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

PRINTED: 03/05/2012
FORM APPROVED
OMB NO. 0938-0391

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	245295	A. BUILDING 02 - MAIN BUILDING B. WING _____	02/15/2012

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K 000	INITIAL COMMENTS	K 000		

RECEIVED
MAR 22 2012
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

DC: 03.28.12

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 FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

POC ok
FS 3-26-12

EXIT: 02-16-2012

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey St Francis Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

PATRICK SHEEHAN
SUPERVISOR
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST PAUL, MN 55101-5145
Email: pat.sheehan@state.mn.us

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President/CEO	3-21-12

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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	245285	A. BUILDING 02 - MAIN BUILDING B. WING _____	02/16/2012

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K 000	Continued From page 1 Fax Number 651-215-0525 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. 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 automatic fire sprinkler system, with quick response heads and installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detectors throughout the corridor system, in areas open to the corridor and common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have automatic fire detectors that are on 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 in accordance with the Minnesota State Fire Code	K 000		

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K 000	Continued From page 2 2007 edition. This facility was surveyed as one building. The facility has a capacity of 120 beds and had a census of 113 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT METas evidenced by:	K 000		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: An interview with various staff and the Minnesota Department of Health Surveyors revealed that cooking is being done outside of the main kitchen, that is not in accordance with NFPA 96 section 1-3.1. This deficient practice could allow the ignition of a build-up of grease that could develop and allow a fire to spread which would negatively impact all the residents, staff and guests of the wing the fire is in. Findings include: Prior to and during the facility tour of February 15, 2012, between 10:35 am and 12:30 pm, interviews with the MDH staff (PK) and facility dietary staff (M and C) revealed that occasionally eggs were being fried in a small amount (less than a tablespoon) of butter or a small amount of cooking spray in all six of the residential style neighborhood kitchens, during the breakfast hour and the kitchens are not separated from the corridor system nor do they have hood	K 069	All LTC staff were verbally told that they can no longer fry eggs with an type of oil, grease, or cooking aid on 2-16-12. A new policy was put into place on 3-12-12 that states that no oils, greases or cooking aids (PAM) can be used in any cooking in the neighborhood kitchens. Staff have been trained how to cook a poached egg (with water only). Random checks will be conducted by licensed staff and PO Director to make sure no oils, greases or cooking aids are be used while cooking. Data from checks will be reported to the QA&A.	3-27-12

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K 069	Continued From page 3 suppression systems installed in accordance with NFPA 96 as required. The Director of Maintenance (SM) verified these findings during the tour of the facility.	K 069	Responsible: Plant Operations Director	
K 072 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Observations of all the exits and exit discharges revealed that three exit discharges are obstructed and do not comply with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.7.2.3. This deficient practice could negatively affect all residents, staff and visitors that need to be quickly evacuated through these exits. Findings include: During the facility tour of February 15, 2012, between 10:35 am and 12:30 pm, revealed that the three north exit discharges, from the Prairie Meadows and River Walk Neighborhoods were covered with snow that had blown in. The Director of Maintenance (SM) verified these findings during the tour of the facility.	K 072	Snow was removed on 2-16-12. Our snow removal policy states that these areas will be checked on a daily basis for snow buildup. We did a complete retraining with maintenance staff on checking these doors daily even if there is no new snowfall on 2-16-12. These accumulations of snow were a result of snow blowing in even though it had not snowed recently. Awareness was made with staff on monitoring exits doors during winter months. A daily checklist for door checks was implemented. Data will be reported to QA&A. Responsible: Plant Operations Director	3-27-12

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5110

March 5, 2012

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5265021

Dear Mr. Nelson:

The above facility was surveyed on February 13, 2012 through February 16, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

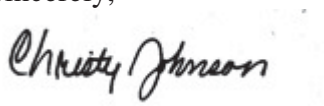
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1705 Fifth Street Northwest, Suite A, Bemidji, Minnesota 56601. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5265s12lic.rtf

Minnesota Department of Health

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 _____	02/16/2012

RECEIVED
MAR 22 2012
Minnesota Department of Health

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: On 2/13, 14, 15, and 16, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President/CEO	3-21-12

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2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.	2 550		

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2 550	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to assess wandering behaviors for 1 of 1 resident (R32) identified with wandering behaviors. Findings include: R32's diagnoses included depression and dementia. The quarterly Minimum Data Set (MDS) dated 11/28/11, identified R32 with cognitive impairments and as requiring extensive assistance with all activities of daily living. The MDS also revealed R32 had difficulty concentrating, became easily annoyed with others, and displayed wandering behaviors that intruded on the privacy of others. The clinical record lacked a comprehensive assessment of the wandering behaviors including: when the behaviors occurred, interventions to decrease the behaviors, and an evaluation of the behaviors. At 1:30 p.m. on 2/15/12, registered nurse (RN)-B stated R32 would wander into other resident rooms and would take the personal items from the rooms. She stated when the staff notice R32 in another resident room, they are to assist her out of the room. She stated R32 was very difficult to redirect at time. She stated she was unaware other residents on the unit were bothered by R32's behavior and was not aware of any family concerns related to R32's behaviors. At that time, she reviewed R32's record and verified the record did not contain a comprehensive assessment of the wandering behaviors. At 1:52 p.m. on 2/15/12, quality of life aide-A	2 550		

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2 550	Continued From page 3 stated she was aware R32 would wander into other resident rooms, but stated she was not aware of the behavior bothering any of the other residents. She stated she would at times attempt to engage the resident in an activity when she was wandering, but it didn't always work. At 2:30 p.m. on 2/16/12, licensed social worker (LSW)-A stated she was aware of R32's wandering behaviors, including behaviors in which she wandered into other resident rooms. She stated some other residents had made concerns related to a resident's wandering behaviors, but she had not investigated the concerns to determine which resident was displaying the behavior to ensure appropriate interventions were in place to decrease the behaviors. She verified she had not completed a comprehensive behavior assessment of R32's behaviors. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing (DON) or her designee could develop policies and procedures to ensure comprehensive assessments are completed at the time of the quarterly MDS. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		

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2 565	Continued From page 4 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide timely assistance with repositioning and toileting according to the plan of care for 1 of 2 (R88) residents in the sample who required assistance. Findings include: R88 was not provided assistance with toileting or repositioning according to the plan of care (POC). The POC dated 1/29/09, indicated R88 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to reposition every 2 hours, and check for incontinence every 2 hours. On 2/15/12, R88 was observed from 7:30 a.m. to 10:00 a.m. (2.5 hours) to be positioned on her right side in bed and was not provided assistance with repositioning or toileting. Nursing Assistant (NA)-H verified findings. On 2/16/12, R88 was observed from 7:30 a.m. to 10:30 a.m. (3 hours) to be positioned in her wheelchair and was not provided assistance with reposition or toileting. R88 was observed to be saturated with urine (thorough clothes). NA-H verified findings.	2 565		

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2 565	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
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, document review and interview, the facility failed to provide appropriate treatment to promote healing of pressure ulcers for 1 of 1 (R88) residents in the sample with pressure ulcers. Findings include:	2 900		

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2 900	Continued From page 6 R88 who had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open area usually over a bony prominence) was not provided timely assistance with repositioning and dressings were not applied according to plan of care. The Full Minimum Data Set (MDS) completed on 10/31/11, indicated R88 required extensive to total assistance with all activities of daily living (ADLs), was at risk for development of pressure ulcers and had severe cognitive impairment. The quarterly MDS completed on 12/30/11, indicated the same as the previous MDS. The plan of care (POC) dated 1/29/09, indicated R88 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to monitor for redness, keep clean and dry, pressure relieving devices in wheelchair and bed, and to reposition every 2 hours. The nursing progress notes indicated: 2/12/12- Quick Note - Dr. (name) notified of open area and treatment to the left buttock 2/12/12 Treatment Orders - Monitor Stage II PU to coccyx, daily at 0800. D/C (discontinue) when healed. The Skin and Wound Flow Sheet indicated: 2/9/12- open lesion to coccyx. 1 cm by 2 cm. Duoderm (dressing for treatment of pressure ulcers) applied. Arginaid added for healing. 2/11/12- Measurement same 2/14/12- 1 cm by 1 cm. Using NCC (barrier cream).	2 900		

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2 900	Continued From page 7 The Temporary Care Plan dated 2/9/12 indicated: Stage II PU - Duoderm q (every) 7 days as needed (prn). Repo every 2 hours. Follow skin/wound guidelines. Treatment orders: 2/11/12 - chart s/w (size/width) stage II PU to coccyx every Tuesday - monitor stage II PU. 2/10/12 - Vit C A Tissue Tolerance Testing form (used to assess appropriate repositioning schedules) dated 2/11/12 for w/c documented R88 had a stage 2 PU to the inner left buttocks and was able to tolerate an every 2 hour repositioning schedule. Refer to skin risk assessment. Add Roho cushion to POC. A Tissue Tolerance Testing form dated 2/10/12 for bed also indicated an every 2 hour repositioning schedule. A Braden Scale (tool for predicting pressure ulcer risk) dated 2/11/12, documented a score of 12 which would indicate high risk. On 2/15/12 at 7:30 a.m. R88 was observed in bed lying on her right side. R88 was observed to remain positioned on her right side in bed until 10:00 a.m. when Nursing Assistant (NA)-H went into her room to provide morning cares. NA-H stated the last time R88 was checked for incontinence or repositioned was at approximately 7:30 a.m.. NA-H added usually R88 gets up earlier but "other priorities prevented that today." Perineal care was provided and a stage 2 pressure ulcer (PU) was observed to the left of the coccyx area measuring approximately 1 cm. There was no dressing to the PU. The PU	2 900		

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2 900	Continued From page 8 was red in color and shallow. NA-H stated the PU was new and she applies cream after cares. She added the Duoderm dressing does not work well on the coccyx as bowel movement (BM) gets under it. R88 was transferred to her wheelchair (w/c) and a Roho cushion was observed in the seat of w/c. On 2/16/12 at 7:30 a.m. R88 was observed up in the w/c in the dining room. She was served breakfast at 8:15 a.m.. At 9:20 a.m. she was wheeled to a seating area at the end of the hall. On 2/16/12 at 9:00 a.m. licensed practical nurse (LPN)-C was questioned about the treatment for the PU and she stated she was not sure if Duoderm was on or not as she had not checked it. She added the nursing assistants will usually tell her if it has fallen off. The electronic medication administration record (MAR) was reviewed with LPN-C and did not include the treatment to check the Duoderm to the PU. At 10:20 a.m. NA-H was questioned about R88's repositioning schedule. She stated she has not gotten to R88 yet and she had to help another resident first. NA-H added that the nurse wanted to check her PU and put Duoderm on. At 10:30 a.m. a nursing assistant was observed to wheel R88 to her room. LPN-C was also in the room. R88 was transferred into bed via hoyer lift. Following perineal care, LPN-C cleansed the PU and applied thin Duoderm to the area. NA-H verified at that time R88 had not been assisted with repositioning since she was gotten out of bed around 7:30 a.m. (3 hours later) and	2 900		

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2 900	Continued From page 9 she should be repositioned every 2 hours. At 10:40 a.m. the Unit Manager (RN-A) was interviewed. She verified the plan of care was not followed and R88 should have been repositioned every 2 hours. RN-A checked the electronic MAR and verified it did not contain a treatment order to check Duoderm on coccyx. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		

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2 910	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence care for 1 of 2 (R88) residents in the sample with incontinence. Findings include: R88 was not provided timely assistance with incontinence care on 2/15/12 and 2/16/12. The Full Minimum Data Set (MDS) completed on 10/31/11, indicated R88 required extensive to total assistance with all activities of daily living (ADLs), was frequently incontinent of urine, and had severe cognitive impairment. The quarterly MDS completed on 12/30/11, indicated R88 was always incontinent or urine due to progression of Alzheimer's disease. The plan of care dated 1/21/09, indicated R88 required assistance with ADLs due to Alzheimer's disease and to check pad for incontinence every 2 hours and as needed. The Bowel and Bladder Assessment dated 10/8/11, updated 12/29/11, indicated R88 had functional incontinence and was on a check and change program every 2 hours. On 2/15/12 at 7:30 a.m. R88 was observed in bed lying on her right side. R88 was observed to remain positioned on her right side in bed until 10:00 a.m. when Nursing Assistant (NA)-H went into her room to provide morning cares. The NA-H stated the last time R88 was checked for incontinence was at approximately 7:30 a.m.. NA-H added usually R88 gets up earlier but	2 910		

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2 910	Continued From page 11 "other priorities prevented that today." Perineal care was provided and R88 had been incontinent of urine. On 2/16/12 at 7:30 a.m. R88 was observed up in the w/c in the dining room. She was served breakfast at 8:15 a.m.. At 9:20 a.m. she was wheeled to a seating area at the end of the hall. At 10:20 a.m. NA-H was questioned about R88's toileting schedule. She stated she has not gotten to R88 yet and she had to help another resident first. At 10:30 a.m. a nursing assistant was observed to wheel R88 to her room. R88 was transferred into bed via hoyer lift. R88's brief was saturated with urine which had leaked through her pants. NA-H verified at that time R88 had not been assisted with toileting since she was gotten out of bed around 7:30 a.m. (3 hours later) and she should be checked every 2 hours. At 10:40 a.m. the Unit Manager (RN-A) was interviewed. She verified the plan of care was not followed and R88 should have been checked for incontinence every 2 hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents receive appropriate incontinence cares. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance.	2 910		

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	00818	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 910	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty one (21) Days	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff served foods in a sanitary manner related to appropriate hand hygiene prior to touching food items during the distribution of food in 3 of 3 dining rooms (Lady Slipper, Wild Flower, Railways). This practice had the potential to affect all 112 residents residing in the facility. Findings include: Lady Slipper/Wild Flower At 5:35 p.m. on 2/13/12, the Prairie Meadows unit was observed to have two dining rooms. The first dining room, Lady Slipper had 15 residents sitting in it. The second dining room, Wild Flower, had 14 residents waiting for their meal. At 5:45 p.m. cook-B donned gloves and began dishing plates for the residents in the Lady Slipper dining room. As she dished the meals, she reached directly into the steam table with her gloved hand and picked up baked potatoes for residents. She also reached into the container of	21015		

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21015	Continued From page 13 dinner rolls and picked up a the dinner roll with her gloves hand. At 5:50 p.m. cook-B flipped through the dietary cards located in a flip folder (kardex) resting on a counter next to the steam table. Cook-B then returned to the steam table wearing the same gloves and again began dishing up the meals for the residents. She was observed to directly touch the dinner rolls and the baked potatoes with the same gloved hands. At 5:52 p.m. the dietary staff completed dishing the meals for the 15 residents and 3 room trays for the Lady Slipper dining room. Cook-B and dietary aide (DA)-C then wheeled the steam table and the meal cart to the Wild Flower dining area. Cook-B and DA-C did not remove their gloves when they moved the carts and the electrical cords for the steam table. At 5:54 p.m. cook-B began dishing the meals for the residents in the Wild Flower dining room. She continued to wear the same gloves as she picked up the baked potatoes and the dinner rolls with her gloved hand. At 6:00 p.m. all 14 residents in the Wild Flower dining room received their evening meal. The dietary staff did not change their gloves during the entire meal service observed. At 8:40 a.m. on 2/15/12, the breakfast meal was observed in the Lady Slipper dining room. The breakfast meal was an open breakfast in which the staff members would prepare the meals for the residents. At 8:41 a.m. nursing assistant (NA)-J began preparing a meal for a resident. She donned gloves and placed bread into a toaster. She	21015		

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21015	Continued From page 14 touched the toaster with her gloved hand. She then went to the freezer and removed a zip lock bag of sausages, opened the bag, and then removed three sausages. She then placed the sausages on a plate, opened the microwave, closed the door, started the microwave and replaced the bag back in the freezer. She then opened a drawer, removed a small bowl and filled it with fruit. She placed the fruit cup on a tray and then went to a small steam table and removed a boiled eggs from the container and proceeded to peel the egg. She placed the pealed egg on a plate, removed the bread from the toaster, buttered it, and removed the sausages from the microwave. She arranged each of the items on the resident's plate touching the food with her gloved hands. At 8:43 p.m. she removed her gloves, picked up the tray and delivered it to a resident on the unit. At 8:44 a.m. NA-K donned a glove on her left hand and placed a slice of bread into the toaster. She then donned a second glove, reached into the steam table and removed a boiled egged, pealed the egg and placed it on a plate. She then opened a drawer, removed a small bowl, filled it with mixed fruit. At 8:45 a.m. she removed the toast from the toaster, buttered it, placed it on the plate and cut the egg with the same gloved hand. She then delivered the meal to a resident in the dining room. At 9:09 a.m. NA-K donned gloves prior to placing bead in the toaster. She kept her gloves on as she walked over to a resident sitting at the kitchen counter. She talked to the resident, touched the resident's hand and the counter. She then returned to the toaster and removed the bread with her same gloved hands. After adding butter and jelly to the toast, she delivered it to	21015		

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21015	Continued From page 15 another resident in the dining room. She was observed to remove her gloves after she had delivered the toast to the resident in the dining room. Railways During meal observation in the Railways dining room at 5:00 p.m. on 2/13/12, 16 residents were being served supper. DA-B donned a pair of gloves without washing her hands first. DA-B took 2 pieces of bread from the bread bag and placed them into the toaster. While the bread was toasting, DA-B opened the upper cupboard and took out a plate, she then opened the silverware drawer and took out a knife. With the same gloved hands DA-B removed the bread from the toaster and proceeded to butter it and then brought it to a resident. DA-B did not wash or sanitize her hands during any of the observed meal service. During observation of the same meal at approximately 5:13 p.m. NA-I was observed wearing gloves. NA-I was assisting the residents with buttering their dinner rolls and applying butter to their baked potatoes. NA-I dropped a pat of butter on the floor, picked it up with the same gloved hands and placed it on the table and continued to assist the residents with buttering their rolls and potatoes. NA-I did not remove her contaminated gloves or sanitize her hands after picking up the butter pat from the floor. On 2/15/12, at 11:27 a.m. on the Railways unit, DA-A donned gloves, but was not observed to	21015		

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21015	Continued From page 16 wash hands or use hand sanitizer prior to serving baked beans to residents. At 11:33 a.m. cook-A touched a piece of paper on the steam table with her gloved hand, then used the same gloved hand to scoop steak fries and handle buns. Cook-A continued to handle steak fries and buns with the same gloved hand until all 19 residents on that unit were served. At 11:48 a.m. cook-A stated, "I don't use tongs to handle the buns or fries generally." She stated she used gloved hands instead of tongs or utensils because it was easier to get the buns open and get the right serving size of the fries. On 2/15/12, at 12:20 p.m. the director of food and nutritional services (DFNS). stated staff should have either used hand sanitizer or washed hands prior to serving resident foods. The DFNS verified after cook-A touched the paper on the steam cart, she should have either washed her hands or used hand sanitizer and changed her gloves prior to serving more food. The DFNS stated the policy directs for staff to use gloves to touch food the resident is going to eat. The DFNS added if staff have touched cabinets or other dirty surfaces, they need to remove those gloves, and either wash or use hand rub, then reapply a glove to handle food. The facility policy titled Hand Hygiene reviewed 5/10, directed staff to wash hands before donning gloves, after removing gloves, and after contact with objects and equipment in the resident's immediate vicinity. SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review	21015		

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21015	Continued From page 17 and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Tweny one (21) days.	21015		
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 ensure proper hand washing while providing care for 1 of 4 (R88) residents in the sample observed to receive cares. Findings include: Staff failed to change gloves and/or wash hands prior to providing pressure ulcer cares for R88. On 2/16/12, at 10:30 a.m. a nursing assistant was observed to wheel R88 to her room. Licensed practical nurse (LPN)-C was also in the room. R88 was transferred into bed via hoyer lift. R88's brief was saturated with urine. LPN-C applied gloves and proceeded to assist with removing the brief and providing perineal care. She then cleansed the pressure ulcer. Without	21375		

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21375	Continued From page 18 removing her gloves, LPN-C then proceeded to pick up the Duoderm (dressing for treatment of pressure ulcers) package (had pre-cut pieces) and then used the soaker pad under R88 to pat dry the coccyx area. LPN-C applied the Duoderm over the pressure ulcer with the contaminated gloves. With the same gloved hands LPN-C grabbed a roll of garbage bags from the resident's drawer and passed them to the nursing assistant. She then removed her gloves and without washing her hands proceeded to adjust clothing, bedding and the hoyer sling. At that point LPN-C used alcohol based foam to disinfect her hands prior to leaving the room. She verified after the observation that she should have changed gloves prior to applying the Duoderm. The Handwashing Policy dated 2/12, indicated the following: Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn, and immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel and/or the environment. Some examples, but not limited to: ... before touching wounds of any kind, ... after touching any item or surface that may have been contaminated. Suggested Method of Correction: The administrator or designee could review policy and procedures regarding infection control. Facility could educate staff on policy and procedures and develop a monitoring system to ensure compliance.	21375		

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21375	Continued From page 19 Time Period for Correction: Twenty one (21) days.	21375		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure that sufficient and appropriate social services interventions were provided for 1 of 1 resident (R32) who exhibited wandering behaviors. Findings include: R32's diagnoses included depression and dementia. The quarterly Minimum Data Set (MDS) dated 11/28/11, identified R32 with cognitive impairments and as requiring extensive assistance with all activities of daily living. The MDS also revealed R32 had difficulty concentrating, became easily annoyed with others, and displayed wandering behaviors that intruded on the privacy of others. The clinical record lacked a comprehensive assessment of the wandering behaviors including: when the behaviors occurred, interventions to decrease the behaviors, and an	21475		

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21475	Continued From page 20 evaluation of the behaviors. The current plan of care printed on 2/16/12, identified R32 as having delusional thinking and exhibiting behaviors such as wandering and combativeness with cares. The care plan interventions identified R32's medications for behaviors that included Seroquel (antipsychotic medication). However, the care plan lacked non-pharmacological interventions to be implemented when R32 displayed the behaviors. Review of the Mood and Behavior documentation from 12/18/11 - 2/15/12, revealed R32 had 14 separate incidents of wandering behaviors. The behavior notes dated 1/2/12, indicated R32 wandered in the evenings and was difficult to redirect. A note dated 1/17/12, indicated R32 had been wandering into other resident rooms and had been difficult to redirect. A note dated 2/7/12, indicated R32 had required assistance to leave another resident's room. Review of the social service notes identified documentation related to R32's behaviors in the past year was lacking. At 4:40 p.m. on 2/13/12, R46 reported R32 would occasionally wander into her room without permission. She stated R32 would take items and it bothered her when R32 would come into her room. She also reported R32 would become loud during meals and during the noon meal on 2/13/12, she had to leave the dining room because of R32's behaviors were making her upset. At 6:00 p.m. on 2/13/12, R32 was observed to eat her evening meal in the dining room without	21475		

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21475	Continued From page 21 incident. At 7:30 p.m. on 2/13/12, R32 was observed in a wheelchair wandering on the Prairie Meadows Neighborhood. She was observed to independently wheel herself down the hallway and look out the exit door. She was not observed to go into any other resident's room. At 9:32 a.m. on 2/14/12, R95 reported R32 would wander into his room and take items without his permission. He stated the staff members were aware that R32 wandered into other residents' rooms. At 10:00 a.m. on 2/14/12, R105's family member (FM-1) stated R32 would occasionally wander into 105's room which was upsetting to R105. She stated the facility staff members were aware of the wandering behaviors. At 1:30 p.m. on 2/15/12, registered nurse (RN)-B stated R32 would wander into other resident rooms and would take the personal items from the rooms. She stated when the staff notice R32 in another resident room, they are to assist her out of the room. She stated R32 was very difficult to redirect at time. She stated she was unaware other residents on the unit were bothered by R32's behavior and was not aware of any family concerns related to R32's behaviors. At that time, she reviewed R32's record and verified the record did not contain a comprehensive assessment of the wandering behaviors. At 1:52 p.m. on 2/15/12, quality of life aide-A stated she was aware R32 would wander into other resident rooms, but stated she was not aware of the behavior bothering any of the other	21475		

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21475	Continued From page 22 residents. She stated she would at times attempt to engage the resident in an activity when she was wandering, but it didn't always work. At 2:03 p.m. on 2/15/12, nursing assistant (NA)-O stated he had been working during the noon meal on 2/13/12. He stated R32 had an episode of being very loud in the dining room and R46 became upset and nervous because of her behaviors and left the dining room. He stated R46 ate her meal in her room because of R32's behaviors. At 2:30 p.m. on 2/16/12, licensed social worker (LSW)-A stated she was aware of R32's wandering behaviors, including behaviors in which she wandered into other resident rooms. She stated some other residents had made concerns related to a resident's wandering behaviors, but she had not investigated the concerns to determine which resident was displaying the behavior to ensure appropriate interventions were in place to decrease the behaviors. She verified she had not completed a comprehensive behavior assessment of R32's behaviors. Suggested Method of Correction: The administrator or designee could review and revise the policy and procedures as related to wandering behaviors. The facility could educate appropriate staff on policy and procedures. The facility could develop a monitoring system to ensure compliance. Time period for Correction: Twenty one (21) days.	21475		
21665	MN Rule 4658.1400 Physical Environment	21665		

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21665	Continued From page 23 A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain an environment free of potential accident hazards in the sitting areas on 2 of 3 neighborhoods (Railways and Prairie Meadows) in which electric fireplaces were in use. This practice had the potential to affect only the independently mobile residents on these units. Findings include: Railways unit Northern Pacific Line/Milwaukee Road Line and Wild Rice River/Red River of the North fireplaces On 2/13/12, at 7:13 p.m. the fireplace located within the lounge between Northern Pacific Line and Milwaukee Road Line, within the Railways unit did not appear to be on as no flame was present. However, along the upper black ventilation grill the fireplace felt very hot to the touch. No residents were present in the lounge at that time. At 7:36 p.m. this fireplace remained the same, no residents were present in the lounge. On 2/14/12, at 8:30 a.m. the fireplace again appeared to be off as no flame was present, yet the upper black ventilation grill along the top of the fireplace was very hot to touch. No residents were in the lounge area.	21665		

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21665	Continued From page 24 At 10:00 a.m. the fireplace remained very hot to touch along the upper black ventilation grill. Four residents in wheelchairs were in the lounge area at that time, the closest resident was approximately 8 feet from the fireplace. None of the residents attempted to propel their wheelchairs. At 11:30 a.m. no residents were in the lounge at this time. The fireplace ventilation grill remained very hot at this time. On 2/14/12, at 2:24 p.m. nursing assistant (NA)-A stated she had never seen the fireplaces on. When shown that the fireplace did not look on, yet was hot to touch along the ventilation grill, NA-A stated she had never noticed that before. NA-A stated she guessed maintenance would turn on the fireplaces. and was not aware of any thermometers used by the fireplaces to monitor the temperature. NA-A stated no residents had ever touched the fireplace and no one had ever sustained a burn that she knew of. On 2/14/12, at 2:27 p.m. NA-B stated the fireplace "hasn't been used this winter." NA-B was brought to the fireplace and verified it was hot to touch. NA-B stated there was no way to monitor the fireplace temperature. NA-B stated, "We wouldn't even know it was on." NA-B stated no residents had touched the fireplace and no one had ever been burned. On 2/14/12, at 2:31 p.m. NA-C stated she had never seen the fireplace on. NA-C stated she had never seen residents feel the fireplace and no one had been burned. On 2/14/12, at 2:34 p.m. the director of plant	21665		

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	00818	A. BUILDING _____ B. WING _____	02/16/2012

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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) COMPLETE DATE
21665	Continued From page 25 operations (DPO) checked the fireplace in the lounge between Wild Rice River and Red River of the North. At that time, the DPO stated, "They are terribly hot." The DPO stated they would be disconnected right now and added they would put up signs that said: do not use. On 2/15/12, at approximately 8:30 a.m. and on 2/16/12, at 8:30 a.m. the fireplace on the Railway unit between the Northern Pacific Line and the Milwaukee Road Line was observed to not feel hot. On 2/16/12, at 9:05 a.m. the unit clerk (UC)-A verified there were 19 residents on these areas affected. Soo Line/Great Northern Line fireplace On 2/13/12, at 7:20 p.m. an electric fireplace between the Soo Line hall and the Great Northern Line hall located on the Railways Neighborhood was observed to be on. The fireplace was approximately 3 feet high by 3 feet wide and 1 foot deep. It had a chain linked screen covering the front of it. The fireplace surround was framed with a 2 inch black metal strip. The surveyor touched the black metal strip which was extremely hot to the touch (could not touch for greater than 1 second.) 1 resident was sitting approximately 15 feet from the fireplace and another resident was sitting further away in a reclining chair. At 8:30 a.m. on 2/14/12, this fireplace was observed to be on. There were no residents in the area as they were eating breakfast. At 9:21 a.m. the fireplace remained on and was extremely hot	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21665	Continued From page 26 to the touch. One resident was sitting in a wheelchair approximately 5 feet from the fireplace. At 10:33 a.m. the fireplace remained extremely hot to the touch. Six residents were seated approximately 4 feet from the fireplace, however, none of the residents were observed to be wandering near the fireplace. At 2:24 p.m. on 2/14/12, NA-E, NA-H, and NA-F stated they had never turned on the fireplace and were not sure how it worked. They added they had not seen any residents get close to the fireplace. At this same time, NA-G stated she had noticed the fireplace running on Sunday morning 2/12/12, and had thought it had been fixed and working again. The director of plant operations (DPO) was interviewed at 2:11 p.m. on 2/14/12, and stated, the staff turned the fireplaces on and off, and he thought they were remote controlled. The DPO added, "I don't really know much about those, they are supposed to check and make sure they are turned off every evening." The DPO added there was not a way to monitor the fireplaces surface temperatures. The DPO stated the maintenance department did not have a policy or a standard preventative maintenance program for the monitoring of the fireplaces, but added he thought the nursing department may have one. On 2/14/12, at 2:38 p.m. registered nurse (RN) Quality and Clinical Financial Coordinator confirmed the nursing department did not have a policy on the use and monitoring of the neighborhood fireplaces. At 2:24 p.m. on 2/14/12, the DPO tested the Railways sides A and B fireplaces. The mantel on Railways A measured 178 degrees	21665		

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21665	Continued From page 27 Fahrenheit, and the mantel on Railways B measured 168 degrees Fahrenheit. The DPO verified that these measurements were not safe and immediately turned both fireplaces off by pulling out the switches that connected to the heat source. The DPO further added, "We did not know they were that hot." Prairie Meadows unit On 2/13/12, at 5:00 p.m. the Prairie Meadow fireplaces were observed to be off. On 2/14/12, at 3:24 p.m. NA-L and NA-M stated they could not recall the last time the fireplaces on the Prairie Meadow neighborhood had been on and were unsure how to turn on the fire places. On 2/13/12, at 2:27 p.m. NA-N stated the fireplaces had been on during the Christmas season but was unsure how to turn it one. On 2/14/12, at 2:30 p.m. RN-B stated the fireplaces on the Prairie Meadow Neighborhood were not used. She stated the fireplaces were equipped with a control panel behind the metal enclosure on the bottom of the fireplace which turned the fireplaces on and off. On 2/15/12, at 9:05 a.m. the maintenance director stated he had removed the main knobs from the fireplaces so they were inoperable. SUGGESTED METHOD OF CORRECTION:	21665		

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21665	Continued From page 28 The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home fireplaces are maintained in a safe manner. Ongoing maintenance, monitoring and record keeping could ensure that the fire places are safe for the residents, staff and visitors. The facility could develop a system to audit the fire places on an ongoing basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		