DEPARTMENT OF HEALT	H AND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: COTG
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00818
1. MEDICARE/MEDICAID PROVID (L1) 245265 2.STATE VENDOR OR MEDICAID N (L2) 003543200		 NAME AND AI (L3) ST FRANCI (L4) 2400 ST FRA (L5) BRECKENE 	S HOME ANCIS DRIVE	LITY	(L6) 56520	4. TYPE OF ACTION: 7_(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 04/	18/2012 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED AS	:		
From (a):		A. In Complia		-	And/Or Approved Waivers Of Th	ne Following Requirements:
To (b):		Program	Requirements		2. Technical Personnel	6. Scope of Services Limit
			ice Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	120 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNF 5. Life Safety Code	 . Patient Room Size 9. Beds/Room
13.Total Certified Beds	120 (L17)	B. Not in Co Requireme	mpliance with Prog ents and/or Applied	ram Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN	1			15. FACILITY MEETS	
18 SNF 18/19 SNF	5 19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	(L15)
120					-	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
Post Certification Revisit to	o verify that the fa	cility has achiev	ed and mainta	ined con	pliance with Federal Certific ility is certified for 120 skill	cation Regulations. Please refer to the
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	
Pam Kerssen, Unit	Supervisor		05/10/2012		Colleen B. Leach, I	Program Specialist 05/10/2012
			DV HCEA DI	(L19)	L OFFICE OR SINGLE ST	(L20)
					21	
19. DETERMINATION OF ELIGIBIL	JTY		APLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	-				3. Both of the Above	:
 Facility is not Eligib 	(L21)					
					1	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	<u>VOLUNTARY</u> <u>00</u>	
06/01/1984					01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	6
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	OTHER
	A. Suspensior	of Admissions:	(L44)			07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	pension Date:	(211)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)	50002		(L31)	POSTED 5/11/2012 ML	-
					-	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
	(L32)	04/13/2012		(L33)	DETERMINATION APPR	OVAL
	. /			,		



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 Jeach

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



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,

an Kume

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245265	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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 Reg. # LSC	483.13(c)	Correction Completed 03/27/2012		F0250 83.15(g)(1)	Correction Completed 03/27/2012	ID Prefix Reg. # LSC	483.20(c)		Correction Completed 03/27/2012
	F0282 483.20(k)(3)(ii)	Correction Completed 03/27/2012	ID Prefix Reg. # 4 LSC	83.25(c)	Correction Completed 03/27/2012	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 03/27/2012
	F0323 483.25(h)	Correction Completed 03/27/2012	ID Prefix Reg. # 4 LSC		Correction Completed 03/27/2012		F0371 483.35(i)		Correction Completed 03/27/2012
ID Prefix Reg. # LSC	483.65	Correction Completed 03/27/2012	Reg. #			Dog #			
ID Prefix Reg. # LSC			Reg. #			ID Prefix Reg. # LSC			Correction Completed
Reviewed I State Agen Reviewed I CMS RO	cy PF	iewed By K/cbl iewed By	Date: 05/10/20	12	of Surveyor: 186 of Surveyor:	518		Date: 04/1 Date:	18/2012
	to Survey Comple 2/16/201				Uncorrected Defic Deficiencies (CN			YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245265	(Y2) Multiple Construction A. Building B. Wing 02 - MA	IN BUILDING	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 03/27/2012	ID Prefix		Correction Completed 03/27/2012	ID Prefix		Correction Completed
-	NFPA 101 K0069		-	NFPA 101 K0072		Reg. #		
Reg. #		Correction Completed	Reg. #		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	ID Prefix Reg. # LSC		Correction Completed
Reg. #					Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC						ID Prefix Reg. # LSC		
Reviewed E State Agen Reviewed E CMS RO	DC/ob	1	Date: 05/10/20 Date:	Signature of Sur Signature of Sur	0	3006	Date: (Date:	04/11/2012
Followup t	o Survey Completed on 2/15/2012	1:				iencies. Was a Summa S-2567) Sent to the Fac		NO



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,

- Kume

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 00818	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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)	ltem		(Y5)	Date
ID Prefix		Correction Completed 04/18/2012	ID Prefix		65	Correction Completed 04/18/2012		ID Prefix			Correction Completed 04/18/2012
		8.0400 Subp.			Rule 4658.0405 Sub				MN Rule 465		
ID Prefix Reg. # LSC	MN Rule 465	Correction Completed 04/18/2012 38.0525 Subp. :		MN F				Reg. #	21375 MN Rule 465		
		Correction Completed 04/18/2012 88.1005 Subp.		MN F		Correction Completed 04/18/2012		ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC					Reg. #			
ID Prefix Reg. # LSC			Reg. #			Correction Completed		ID Prefix Reg. # LSC			
Reviewed E State Agen Reviewed E	cy	Reviewed By PK/cbl Reviewed By	Date: 05/10/20 Date:	012	Signature of Sur	18	618			Date:	4/18/2012
CMS RO Followup t	to Survey Con 2/16	-	Dalë:	Cł	heck for any Uncorn Uncorrected Defic Page 1 of 1	rected Defic					NO

DEPARTMENT OF H	EALTH AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: COTG
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00818
1. MEDICARE/MEDICAID F (L1) 245265		3. NAME AND AE (L3) ST FRANCI	S HOME	LITY		 4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDI (L2) 003543200	CAID NO.	(L4) 2400 ST FRA			(L6) 56520	3. Termination 4. CHOW 5. Validation 6. Complaint
000040200		(L5) BRECKENF	dDGE, MN			5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHAN (L9)	IGE OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	02/16/2012 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATE	US:(L10)	03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIF	ICATION	10.THE FACILITY	IS CERTIFIED AS	8:		
From (a):		A. In Complia			And/Or Approved Waivers Of T	
To (b) :			Requirements ce Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	120 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNI	
					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	120 (L17)		mpliance with Prog ents and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BI	REAKDOWN				15. FACILITY MEETS	
18 SNF 18	8/19 SNF 19 SNF	ICF	IMR		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	120 (L38) (L39)	(L42)	(L43)			
(E37)	(E50) (E57)	(142)	(145)			
At the time of the Sta	CY REMARKS (IF APPLICABL ndard survey, the facility fe safety code along with	y was not in Subs	stantial Compl	iance wi	th Federal Certification Reg Certification Revisit to follo	ulations. Please refer to the CMS 2567
17. SURVEYOR SIGNATUR		Date :			18. STATE SURVEY AGENCY	
Rebecca Haber	le, HFE NE II	04/02/	2012	(L19)	Colleen B, Leach,	Program Specialist 04/13/2012
	PART II - TO BE	E COMPLETED	BY HCFA RI	. ,	L OFFICE OR SINGLE ST	
19. DETERMINATION OF E	LIGIBILITY ligible to Participate		IPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is r					5. Bour of the Above	
2. Tachity is i	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 06/01/1984	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 00 01-Merger, Closure 01	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursem	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DAT		VF SANCTIONS	(120)		03-Risk of Involuntary Termination	OTHER
20. Die Little Giote Ditt		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	-		(L44)			00-Active
	(L27) B. Rescind Sus	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/0	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)	POSTED 4/13/20	012 ML
31. RO RECEIPT OF CMS-15	539 32	DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPR	ROVAL



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;

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

St Francis Home March 5, 2012 Page 4

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.

St Francis Home March 5, 2012 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

St Francis Home March 5, 2012 Page 6

Feel free to contact me if you have questions.

Sincerely,

Christy Johnson

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

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	RECEIVED	PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245265	B. WING	Minneston Department of Health Bernidi	02/16/2012
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	T 5 2 7
ST FRAM				2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMEN	78	FOC		1
	es your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the age of the CMS-2567 form will ion of compliance.	 }		
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the mattained in accordance with	: ! :		:
F 226 SS=C	483.13(c) DEVELO ABUSE/NEGLECT		F 22	6 St. Francis Home will	3-27-12
	The facility must de policies and proced mistreatment, negle	velop and implement written		continue to report alleged violations involving mistreatment, neglect, or abuse, including injuries unknown source and	
	by: Based on interview facility failed to deve procedures related of the administrator investigation of thes	T is not met as evidenced and document review, the elop appropriate policies and to the immediate notification and the State agency and the se allegations. This practice affect all 112 residents in the I survey.		misappropriation of resid property immediately to t administrator/designees a other officials in accordan with Federal and State lay Vulnerable Adult Abuse Neglect Reporting	the and to nce ws.
	Findings include:			Policy/Procedure will be updated to meet requirem	ients
	9/2011, revealed the incl investigated the incl However, the facility	ulnerable adult reports since e facility had reported and dents/allegations timely. r's policy and procedures and investigating allegations	10000000000000000000000000000000000000	related to immediate notification of the administrator/designee ar	ıd
LABORATORY	DIRECTOR'S CR PROVID	ERSUP LIER REPRESENTATIVE'S SIG		TILE	(X6) DATE
Any deficienc	ZINX (N	DAUT Antoine & deficiency wh	ich the instit	President/CE0	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.

 \mathbf{C}

		AND HUMAN SERVICES			FORM): 03/05/2012 A APPROVED): 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245265	B. WING		02/	16/2012
	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 226	required component The Vulnerable Ad Reporting policy da updated in 9/2011, directed to notify the agency immediated neglect and mistreat indicated: "Any person empl Campus who ident maitreatment will in to the Social Worked (variance form) to it is not needed, inver- social Work when of Common Entry Poi "Administration/vice Services or the Administration/vice Services or the Administ	and mistreatment lacked its. ult/Child Abuse and Neglect ited 4/2006, with excepts identified staff were not e administrator and State y of all allegations of abuse, atment. The following excerpts oyed by St. Francis Healthcare ifies a situation involving nmediately report the variance er for that facility." er/designee uses the form nvestigate, If immediate action stigation can be done by the on duty. Must be reported to nt within 24 hours." e President of Nursing ministrative person on call is ernal reporting, but no longer with the person who identified tion, the Social will decided whether the ble to the common entry point." Is Identified, the Supervisor Is their immediate Supervisor."	F 22	the State Agency by Marc 2012. The revised policy/procedure will be reviewed at the licensed st meetings on March 23 and March 26. To make sure to policy/procedure stays cun the MDH and CMS websi will be checked monthly f changes related to mistrea neglect, and abuse of reside and misappropriation of resident property. Any law changes that affect this policy/procedure will be d on a timely basis and all st will be made aware of cha through inservicing. QA& will have a standing agence item to include CMS/MDF changes for reporting purp Responsible: VP of Healt Services.	taff the trent, tes for any tment, lents w lone taff inges &A la H posses.	

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility (D: 00818

If continuation sheet Page 2 of 32

PRINTED: 03/05/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 8. WING 245265 02/16/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2400 ST FRANCIS DRIVE ST FRANCIS HOME BRECKENRIDGE, MN 56520 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 10 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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. PRINTED 03/05/2012 mental findications of abuse are found, the Director of TORGER PROVED Nursing and/or Administrator/designee must be Quartino, 6578-1351 1914 Alt NATION IN CONTRACTOR والمراجعة والمراجع و LODE ONLY SORVEY C. CRECTION 0.1444.00 ٢. Prove the structure of the ٠. findings reported in writing to the 1 04/10/2015 Administrator/designee as soon as possible, but instance of the alleged in the alleged CONTRACTOR OF A DRIVE OF A DODE incident." 1. 上部版 的内部 计可以的图示 1.0040000 grav (0520) Alexandria - Alexandria - Constant
 Alexandria - Constant
 Alexandria - Constant
 Alexandria - Constant
 Alexandria - Constant patients, resident, or clients of a facility, or self 1000-01004 22 14 670 abuse behavior by these person doe not Contraction of the state of the state of the 94.4 constitute abuse unless the behavior causes serious harm." At 3:58 p.m. on 2/14/12, licensed social worker (ESW)-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 Received and a second 1. 1. 5. 5. 6 1 1 1 1 administrator had established an on call system. . However, the facility policy did not include which المترية بالمراجعة and the second sec 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 1. 1. 10 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: COTG11

Facility ID: 00818

If continuation sheet Page 3 of 32.

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI		(X3) DATE SURVEY COMPLETED
245265		245265	8. WING		02/16/2012
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				REET ADDRESS, CITY. STATE, ZIP CO 2400 ST FRANCIS DRIVE	
		TEMENT OF DEFICIENCIES		BRECKENRIDGE, MN 56520 PROVIDER'S PLAN OF CO	ORRECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 226	Continued From pa	ige 3	F 226	3.	
		day - Friday but on weekends			
		is absence, the other obers had full authority to			
	address any conce	ms related to abuse and			PRICIED 03/05/201
nen an	system, but verified	the facility utilized the on call I this authority had not been			PTVC19994 APPED 7
a a La	developed into a w	ritten policy.		n en 21(8). L'en 21(8)	AX DATE SHEVE?
o Pizatio	60000000000000000000000000000000000000	5/12, LSW-A reviewed the			CONFLE IOD
	facility policy. She	stated during the summer of		a unative satisfies in the S	
		d worked on their abuse and		··· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ··	
1941 - M. X		reporting system. She stated le operational adjustments		n an an Article	.4
		rming the facility administrator			
	and the State agen	cy of any alleged abuse and			• •
		mmediately. She verified the cy had not been fully updated			
		immediately report the			
	allegations to the a agency immediatel	dministrator and the State y.			
		16/12, LSW-A provided a copy 2/15/11, in which the facility			
		ral areas of the vulnerable			
	adult policy which t	hey felt were in need of			and the second secon Second second
		uded some of the identified			an a
		r. LSW-A stated she had sent nembers of the facility staff,		an a	 A state of the sta
	but they had not ha rewrite the policy.	d a chance to meet and She verified the policy was in		• · · · ·	
F 250 SS=D	need of revision. 483.15(g)(1) PROV RELATED SOCIAL	ISION OF MEDICALLY	F 250	St. Francis Home	will 3-27-12
				continue to provid	le
	The facility must pro-	ovide medically-related social		medically-related	social
	practicable physica well-being of each r	maintain the highest , mental, and psychosocial		services to attain o	or

If continuation sheet Page 4 of 32

PRINTED: 03/05/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A BUILDING B WING_ 02/16/2012 245265 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 2400 ST FRANCIS DRIVE ST FRANCIS HOME BRECKENRIDGE, MN 56520 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 250 F 250 Continued From page 4 maintain the highest practicable physical, mental, and psychosocial well-being of each This REQUIREMENT is not met as evidenced 03/05/2912 resident. A comprehensive FORM DEPART DY AT OF COM APPROVED. Based on observation, interview, and document interdisciplinary wandering MAS MC 19838-0391 review, the facility failed to assure that sufficient LASS COMPARIANCE / assessment policy and ara parkal and appropriate social services interventions oct - h i i Ch procedure was developed on 3were provided for 1 of 1 resident (R32) who exhibited wandering behaviors. 19-12. The wandering 621 812012 assessment policy and state in Eindings include: procedure will be reviewed at 310 - 42 R32's diagnoses included depression and the licensed staff meetings on dementia. The quarterly Minimum Data Set March 23 and 26, 2012. (MDS) dated 11/28/11, identified R32 with Quality assurance monitoring cognitive impairments and as requiring extensive put into place and will be assistance with all activities of daily living. The MDS also revealed R32 had difficulty completed by Social Services. concentrating, became easily annoved with 140 OA&A Committee to monitor others, and displayed wandering behaviors that - i'u' results. intruded on the privacy of others. The clinical record lacked a comprehensive Responsible: DON assessment of the wandering behaviors . . including: when the behaviors occurred, Sinterventions 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. FORM CMS-2587(02-99) Previous Versions Obsolete Event ID: COTG11 Facility ID 00818 If continuation sheet Page 5 of 32

	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING		(X3) DATE SURVEY COMPLETED
		245265	B WING		02/16/2012
	ROVIDER OR SUPPLIER		240	ET ADDRESS, CITY, STATE ZIP CODE 0 ST FRANCIS DRIVE ECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIEN)	ATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DLFICIENCY)	OULD BE COMPLETE
۴ 250	Continued From p	age 5	F 250		
	from 12/18/11 - 2/ separate incidents	od and Behavior documentation 15/12, revealed R32 had 14 s of wandering behaviors.			
	wandered in the e redirect. A note d	s dated 1/2/12, indicated R32 venings and was difficult to ated 1/17/12, indicated R32 had no other resident rooms and			909907, 1999 1999 (1997) 1999 (1997) 1997
· · · .	had been difficult	to redirect. A note dated 2/7/12, required assistance to leave		an a	1
• • • • •		ial service notes identified ated to R32's behaviors in the king.		n die State Beite Au Geboord van die State State Geboord van die State State State	- ERSS - ALLer ALLER - SECASE
	occasionally wand permission. She a and it bothered he her room. She als loud during meals	13/12, R46 reported R32 would ler into her room without stated R32 would take items ir when R32 would come into so reported R32 would become and during the noon meal on			алыр — Калар — — — — — — — — — — — — — — — — — — —
14. j. 1. j.		o leave the dining room behaviors were making her			an Bellandar († 1949) 1949 - Standard († 1949) 1949 - Standard († 1949)
		13/12, R32 was observed to eat in the dining room without			• • • •
	wheelchair wande Neighborhood. St independently whe	13/12, R32 was observed in a ring on the Prairie Meadows he was observed to hel herself down the hallway kit door. She was not observed r resident's room.			

CENTER STATEMENT	S FOR MEDICARE	AND HUMAN SERVICES		ULTIPLE	CONSTRUCTION	OMB NO	M APPROVI <u>D. 0938-03</u> SURVEY LETED
		245265		NG	······································	02	16/2012
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE 2IP CODE		
ST FRAM	ICIS HOME				CKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(XS) COMPLETIC DATE
	wander into his roc permission. He sta	4/12, R95 reported R32 would om and take items without his ated the staff members were indered into other residents'	F	250		in Cha	: anabata Sapertu A
an a	(FM-1) stated R32 into 105's room wh	/14/12, R105's family member would occasionally wander lich was upsetting to R105. lity staff members were aware				KHOK (F U THE	9 (6836) 84800 3 Mie 1888 - 512
an a		פוומעוטיס.					
	stated R32 would y rooms and would t the rooms. She sta in another resident out of the room. S to redirect at time, other residents on R32's behavior and concerns related to time, she reviewed record did not cont	5/12, registered nurse (RN)-B wander into other resident ake the personal items from ated when the staff notice R32 room, they are to assist her he stated R32 was very difficult She stated she was unaware the unit were bothered by 5 was not aware of any family b R32's behaviors. At that R32's record and verified the ain a comprehensive wandering behaviors.					
	stated she was awa other resident room aware of the behav residents. She sta to engage the resid was wandering, bu At 2:03 p.m. on 2/1 stated he had been	5/12, quality of life aide-A are R32 would wander into hs, but stated she was not for bothering any of the other ted she would at times attempt lent in an activity when she t it didn't always work. 5/12, nursing assistant (NA)-O t working during the noon meal ted R32 had an episode of					

ENTERS		I AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	IX31 DATE SURVEY COMPLETED
		245265	8 WING	······································	02/16/2012
AME OF PRO	DVIDER OR SUPPLIER			REET ADDRESS. CITY, STATE ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CHOSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI
F 250 (Continued From pa	3ge 7	F 25	0	
k 1	became upset and behaviors and left	the dining room and R46 nervous because of her the dining room. He stated n her room because of R32's			a da 1000 an - 2000 An - 2000 an - 2000 An - 2000 an - 2000 an - 2000
сан стану 1 м 1 м 1 м 1 м 1 м 1 м 1 м 1 м 1 м 1 м	LSW)-À stated sh vandering behavic vhich she wandere She stated some o	6/12, licensed social worker e was aware of R32's ors, including behaviors in ed into other resident rooms. other residents had made b a resident's wandering			n fabrich fan Arien 1995 - Andrea 1997 - And
i i i i i i i i i i i i i i i i i i i	oncerns to detern lisplaying the beha nterventions were whaviors. She ve	had not investigated the nine which resident was avior to ensure appropriate in place to decrease the prified she had not completed a havior assessment of R32's			
	83.20(c) QUARTE EAST EVERY 3 N	ERLY ASSESSMENT AT	F 270	St. Francis Home will	3-27-12
(8	juarterly review ins	ess a resident using the strument specified by the State MS not less frequently than hs.		continue to provide medically-related social services to attain or maintain the highest practicable physical, mer	ıtal,
t: 	y: Based on interviey aclility failed to ass	NT is not met as evidenced v, and document review, the ess wandering behaviors for 1 identified with wandering		and psychosocial well-be of each resident. A comprehensive interdisciplinary wanderi assessment policy and	
F	indings Include:			procedure was developed	on
F	32's diagnoses in	cluded depression and		3-19-12. The wandering	

		HAND HUMAN SERVICES				FORM): 03/05/2012 A APPROVED): 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE (COMPL	
		245265	B. WIN	IG	······································	02/	16/2012
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS CITY, STATE, ZIP CODE		
ST FRAI	NCIS HOME				100 ST FRANCIS DRIVE RECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY+	DULD BE	(X5) COMPLETION DATE
F 276	Continued From pa	age 8	F2	276	(1
	dementia. The qui	arterly Minimum Data Set			assessment policy and		
	(MDS) dated 11/28	8/11, identified R32 with			procedure will be reviewe	ed at	
		ints and as requiring extensive activities of daily living. The			the licensed staff meeting	is on	
DEPAR	MDS:also revealed	R32 had difficulty			March 23 and 26, 2012.	- 科特林18日 下①民徒	APPROVE
CENT	- concentrating, bec	ame easily annoyed with			Quality assurance monito	rings NC	0238-039
TEREN	, intruded on the priv	ed wandering behaviors that		- e .	put into place and will be	1.33512441.3	UGMEY BIEC
ervit Pasta a	Multinestale text and large				completed by Social Serv	rices.	
		lacked a comprehensive			QA&A Committee to mo results.	nitor our	- 2752 812
na an a		wandering behaviors behaviors occurred,			results.	1 V.D	1973, 1973, 1975 1973, 1973, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 19 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975, 1975
	interventions to de	crease the behaviors and an			- Anna Anna Anna Anna - 一部構成的		
이 안설	evaluation of the b	ehaviors.			Responsible: DON		
	At 1:30 n.m. on 2/1	5/12, registered nurse (RN)-B				· · · · · · · · · · · · · · · · · · ·	and a second s
• •	stated R32 would v	vander into other resident					n en andre de la constante General
	rooms and would ta	ake the personal items from			· · · · · ·		
		ated when the staff notice R32 room, they are to assist her					
		he stated R32 was very difficult			· · · ·	* · -	
	to redirect at time.	She stated she was unaware			 A state of the second se		
		the unit were bothered by					
		was not aware of any family R32's behaviors. At that			• • •	in en el Children de la	23999231
1	time, she reviewed	R32's record and verified the			· · .		
		ain a comprehensive			and the second secon		and a second s
n da Para Maria	assessment of the	wandering behaviors.			1 4 4 4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n ep e si abri	eren na eren eren eren eren eren eren er
	At 1:52 p.m. on 2/1	5/12, quality of life aide-A			· · · · · · · · · · · · · · · · · · ·		
	stated she was awa	are R32 would wander into					
	ever resident room	is, but stated she was not for bothering any of the other			ter in the second s		
- ⁻	residents. She stat	ed she would at times attempt			$s = (p \cdot \theta)$		
	to engage the resid	ent in an activity when she					
	was wandering, but	it didn't always work.					
	At 2:30 p.m. on 2/1	6/12, licensed social worker				· · · ·	
				-			

FORM CMS-2567(02-99) Previous Versions Obsolete

 $= 2\pi e^{-2} e^{2\pi i \theta}$

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Facility ID: 00818

If continuation sheet Page 9 of 32

		AND HUMAN SERVICES				NTED: 03/05// FORM APPRO B N <u>O: 0938-0</u>	VED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N A. BU			DATE SURVEY COMPLETED	
		245265	B WI	NG_		02/16/2012	
	PROVIDER OR SUPPLIER			2	REFT ADDRESS CITY, STATE ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	id Pref Tac	-IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)		
	wandering behavio which she wanders She stated some o concerns related to behaviors, but she concerns to detern displaying the behavior	age 9 e was aware of R32's ors, including behaviors in ad into other resident rooms. ther residents had made o a resident's wandering had not investigated the nine which resident was avior to ensure appropriate in place to decrease the	F	276	Service Service Service Service Service	erro - Boast Filippes - Ro Sto Doctor D a russ - Rock Gerood	
F 282	behaviors. She ve comprehensive be behaviors:	prified she had not completed a havior assessment of R32's RVICES BY QUALIFIED	F	282	St. Francis Home will continue		••••••
	: must be provided t	ded or arranged by the facility by qualified persons in ach resident's written plan of			to ensure that services provided will be provided by qualified persons in accordance with eac resident's written plan of care. The resident care sheets that al	h	
	by: Based on observa review, the facility f assistance with rep according to the pla residents in the sar Findings include: R88 was not provid repositioning accor The POC dated 1/2 risk for skin breakd and incontinence.	NT is not met as evidenced tions, interview and document alled to provide timely ositioning and toileting an of care for 1 of 2 (R88) nple who required assistance. ed assistance with toileting or ding to the plan of care (POC). 9/09. Indicated R88 was at own due to decreased mobility nterventions included to ours, and check for			NA-R's carry have been updated to include residents the have pressure ulcers and the priority of every 2 hour repositioning. The nursing stat 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	at ff	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00818

If continuation sheet Page 10 of 32

		AND HUMAN SERVICES				FORM	03/05/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	AULTIPL IILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245265	8 WI	NG		02/16	5/2012
	Rovider or supplier			240	ET ADDRESS, CITY. STATE ZIP CODE 0 ST FRANCIS DRIVE ECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED (O THE APP DEFICIENCY)	JULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 10	F	282			1
	incontinence every	-			meeting. Quality assura	ance	
	O- 04640 D00	and the second factor 7,00 a month			monitoring put into plac	ce and	
	- 0/1 2/10/12, R00 w - 10:00 a.m. (2.5 ho	vas observed from 7:30 a.m. to urs) to be positioned on her			will be completed by lic		NEG 0029
nepage	right side in bed an	id was not provided assistance			staff. QA&A Committe	e to _{ORM}	
医软链	 with repositioning (NA)-H verified find 	or toileting. Nursing Assistant			monitor results.		
11 19 241 1997 - 197		20195.				143-1240 - 30 1980 - 1	
		as observed from 7:30 a.m. to			Responsible: DON	• •	
	10:30 a.m. (3 hour to be positioned in	s) her wheelchair and was not					1 256-3
	provided assistance	e with reposition or toileting.					
· · .		to be saturated with urine			the second se		
F 314	483.25(c) TREATM	NA-H verified findings.	F	314	a bar dan san barta bar Anna a san san san san san san san san sa		
		PRESSURE SORES	,	•••	St. Francis Home will c	ontinue	3-27-12
	Deced an ibe com				to ensure that services p		
		prehensive assessment of a y must ensure that a resident			will be provided by qua		
	who enters the fac	ility without pressure sores			persons in accordance w		
	does not develop p	pressure sores unless the condition demonstrates that			resident's written plan o		
		able; and a resident having			The resident care sheets		
	pressure sores rec	eives necessary treatment and			NA-R's carry have been		
		e healing, prevent infection and			updated to include resid	• •	
1	prevent new sores	irom developing.			have pressure ulcers and	1. The second	이 관련
arte et	New York Commence				priority of every 2 hour		in an
	This REQUIREME by:	NT is not met as evidenced			repositioning. The nurs		
		tion, document review and			will also carry the reside	-	• . · .
	interview, the facilli	y failed to provide appropriate			sheet to assist in remind		
		te healing of pressure ulcers			R's regarding importanc	-	
	pressure ulcers.	wano ni ne sample wat			repositioning with press		
					ulcers. This new practic		
	Findings include:				reviewed at the licensed		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: COTG11		Facility	ID 00818 If contin	uation sheet P	

		ND HUMAN SERVICES				FORM	: 03/05/2012 APPROVED : 0938-0391
STATEMENT OF DEFICI	ENCIES ()	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M(A 80/IL			(X3) DATE S COMPL	
		245265	8 WIN	G		02/1	6/2012
NAME OF PROVIDER O				24	EET ADDRESS, CITY STATE, ZIP CODE 00 ST FRANCIS DRIVE RECKENRIDGE, MN 56620	:	
PREFIX (EAC	H DEFICIENCY M	EMENT OF DEFICIENCIES AUST BE FRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF OFFICIENCY)	HOULD BE	(XS) COMPLETION DATE
thicknes open an not prov and dre of care. The Full 10/31/1 total ass (ADLs), ulcers a The qua indicate plan of c was at r mobility to monit pressure	o had a stage as loss of den ea usually ov vided timely a asings were r sistance with was at risk for nd had sever arterly MDS c d the same a care (POC) d isk for skin bi and incontine tor for rednes	a 2 pressure ulcer (partial mis presenting as a shallow er a bony prominence) was ssistance with repositioning not applied according to plan ata Set (MDS) completed on 188 required extensive to all activities of daily living or development of pressure e cognitive impairment. ompleted on 12/30/11. s the previous MDS. The ated 1/29/09, Indicated R88 reakdown due to decreased ance. Interventions included s, keep clean and dry, vices in wheelchair and bed,	F 3	14	meetings on 3-23&26, 2 at the NA-R meeting on 12. Quality assurance monitoring put into plac will be completed by lic staff. QA&A Committe monitor results. Responsible: DON-	a 3-21-	<u>9923-03</u> 4 977 10
The nur	sing progress	notes indicated:					
2/12/12- area and 2/12/12	Quick Note d treatment to Treatment O	- Dr. (name) notified of open o the left buttock rders - Monitor Stage II PU 00. D/C (discontinue) when					
The Skir	n and Wound	Flow Sheet indicated;			- 	*.:	2
Duodern ulcers) a 2/11/12-	n (dressing fo applied. Argin Measureme	o coccyx. 1 cm by 2 cm. or treatment of pressure aid added for healing. nt same n. Using NCC (barrier					
ORM CMS-2567(02-99) Pri	évious Versions Ol	ssolele Event ID COTG	11	Fach	ty 10 00818 If con	tinuation sheet	Page 12 of 32

DEPART	MENT OF HEALTI	H AND HUMAN SE	RVICES				FORM	: 03/05/2012 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPP IDENTIFICATION	NUMBER	(X2) MUL A BUILOI			(X3) DATE S COMPL	
1		2452	65	B WING			02/1	6/2012
					REET ADDRESS CITY, S 2400 ST FRANCIS DRIV BRECKENRIDGE, MI	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRE	OULD BE	IX5) COMPLETION DATE
F 314	Continued From p cream).	age 12		F 31	4			
15,477 († 15,475) 19,465) 19,465	The Temporary Co Stage [I PU - Duod needed (prn). Repo every 2 hour Follow skin/wound	` \$.			1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1			erkek s
	Treatment orders: 2/11/12 - chart s/w coccyx every Tues 2/10/12 - Vit C	r (size/width) stage sday - monitor stag	II PU to e II PU.			· · · · · · · · · · · · · · · · · · ·	: 	e lefthe e l
	appropriate reposi 2/11/12 for w/c do PU to the inner lef tolerate an every 2 Refer to skin risk a to POC. A Tissue	e Testing form (us tioning schedules) cumented R88 had t buttocks and was t hour repositioning assessment. Add F Tolerance Testing to indicated an eve dule.	dated a stage 2 able to schedule. Roho cushion form dated					• ·
	A Braden Scale (to risk) dated 2/11/12 which would indica	ool for predicting pi l, documented a s ate high risk.	essure ulcer core of 12				· ·	
	On 2/15/12 at 7:30 lying on her right s remain positioned 10:00 a.m. when N into her room to pr stated the last time Incontinence or re approximately 7:3 R88 gets up earlie that today." Perine	ide, R88 was obse on her right side in lursing Assistant (I ovide morning car R88 was checked bositioned was at 0 a.m., NA-H adde r but "other prioritie	rved to bed until NA)-H went es. NA-H I for d usually es prevented					
FORM CMS-25	67(02-99) Previous Version	s Obsolete	Event ID COTG11	F	ac-lity (D. 00818	If conti	nuation sheet	Page 13 of 32

		AND HUMAN SERVICES				OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	NULTIPLE CO ILDING		(X3) DATE SURVEY COMPLETED
		245265	8 Wil	NG		02/16/2012
NAME OF	PROVIDER OR SUPPLIER		 ,	STREET A	DORESS. CITY STATE, ZIP CODE	
ST FRA	NCIS HOME			1	FRANCIS DRIVE KENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX.	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED 10 THE APF DEFICIENCY)	OULD BE COMPLETION
F 314	Continued From pa	age 13	F	314		
	stage 2 pressure u left of the coccyx a cm. There was no was red in color an was new and she a added the Duoderr on the coccyx as b under it. R88 was t	Icer (PU) was observed to the rea measuring approximately 1 dressing to the PU. The PU d shallow. NA-H stated the PU applies cream after cares. She in dressing does not work well owel movement (BM) gets ransferred to her wheelchair sushion was observed in the			<u>.</u>	Net (Too), 1977 east (Prese Secondary) (Second Secondary) (Secondary) (Secondary) (Secondary) (Secondary) (Secondary) (Secondary) (Secondary)
 	an a				an a	
, 1 ⁰	the w/c in the dinin breakfast at 8:15 a	a.m. R88 was observed up in g room. She was served .m., At 9:20 a.m. she was ng area at the end of the hall.			antona Secondaria Secondaria	
	(LPN)-C was quest the PU and she sta Duoderm was on o it. She added the n tell her if it has falle The electronic med (MAR) was reviewed	a.m. licensed practical nurse lioned about the treatment for sted she was not sure if r not as she had not checked ursing assistants will usually en off. lication administration record ed with LPN-C and did not int to check the Duoderm to				
	repositioning scheo gotten to R88 yet a resident first. NA-H	I was questioned about R88's fule. She stated she has not nd she had to help another added that the nurse wanted nd put Duoderm on.			 	
	to wheel R88 to he	sing assistant was observed ir room. LPN-C was also in the isferred into bed via hoyer lift.				
ORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID COTG1		Facility ID	00818 If contr	nuation sheet Page 14 of 3

		I AND HUMAN SERVICES				FORM): 03/05/2012 APPROVED): 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l' '	ultiple Lding	CONSTRUCTION	(X3) DATE 5 COMPL	
		245265	в Wi	IG	· · · · · · · · · · · · · · · · · · ·	02/1	16/2012
	Rovider or supplier			2400	T ADDRESS, CITY, STATE. ZIP CODE ST FRANCIS DRIVE ICKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IVLD BE	(X5) COMPLETION DATE
F 314	and applied thin Du NA-H verified at the assisted with repo- out of bed around 7 she should be repo- At 10:40 a.m. the L interviewed. She ve	care, LPN-C cleansed the PU loderm to the area. at time R88 had not been sitioning since she was gotten 7:30 a.m. (3 hours later) and sitioned every 2 hours. Unit Manager (RN-A) was erified the plan of care was not	£.	314			- <u>Sul</u> os (1932) - Stan Stans - Stan Stans 19
	followed and R88 s every 2 hours. RN- and verified it did n check Duoderm on '483.25(d) NO CAT RESTORE BLADD Based on the resid assessment, the fa resident who enters indwelling catheter resident's clinical or catheter/zation was who is incontinent of treatment and servi infections and to re function as possible This REQUIREMEN by: Based on observat review, the facility fa assistance with inco	hould have been repositioned A checked the electronic MAR of contain a treatment order to coccyx. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F	315	St. Francis Home will continue to ensure that residents who are income of bladder receive appro- treatment and services to prevent UTI's and to res- as much normal bladder function as possible. St. Francis Home will conti- ensure that services prov- will be provided by qual persons in accordance w each resident's written p care. The resident care so that all NA-R's carry ha- been updated to include residents that have press	tinent opriate o store nue to vided lified vith olan of sheets ve	3-27-12
	•	ed timely assistance with			ulcers and the priority of		

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Facility ID 00818

If continuation sheet Page 15 of 32

		AND HUMAN SERVICES				D: 03/05/201 MAPPROVEI D: 0938-039
STATEMENT OF	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A BUIL	Detiple construction Ding	(X3) DATE COMP	SURVEY LETED
		245265	B. WIN	G	02/	16/2012
NAME OF PRO	VIDER OR SUPPLIER			STREET AUDRESS, CITY STATE, ZI 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 5652		
(X4) ID PREFIX TAG	(EACH DEFICIENC'	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER S PLAN DE	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 315 C	ontinued From pa	iae 15	F3	15		
in T 14 tc tc tc tc tc tc tc tc tc tc tc tc tc	continence care of he Full Minimum (D/31/11, indicated tal assistance with DLs), was freque ad severe cognitiv the quarterly MDS dicated R88 was ue to progression an of care dated quired assistance sease and to che hours and as nee he Bowel and Bla D/8/11, updated 1 notional incontine tangé program ev	Data Set (MDS) completed on R88 required extensive to h all activities of daily living ently incontinent of urine, and re impairment completed on 12/30/11, always incontinent or urine of Alzheimer's disease. The 1/21/09, indicated R88 with ADLs due to Alzheimer's ck pad for incontinence every ided. dder Assessment dated 2/29/11, indicated R88 had ince and was on a check and	F 3	every 2 hour report The nursing staff carry the resident assist in remindin regarding importar repositioning with ulcers. This new be reviewed at the staff meetings on 2012 and at the N meeting on 3-21- assurance monitor place and will be by licensed staff. Committee to mo	will also care sheet to g NA-R's ince of pressure practice to e licensed 3-23&26, A-R 12. Quality ring put into completed QA&A	
ly re 11 In N in N C C C	ing on her right si main positioned o 0:00 a.m. when N to her room to pro A-H stated the las continence was a A-H added usuall ther priorities pre	de. R88 was observed to be her right side in bed until ursing Assistant (NA)-H went ovide morning cares. The st time R88 was checked for t approximately 7:30 a m. y R88 gets up earlier but vented that today." Perineal and R88 had been incontinent		Responsible: DO	Ν	
th br	e w/c in the dining eakfast at 8:15 a.	a.m. R88 was observed up in groom. She was served m At 9:20 a.m. she was g area at the end of the hall.			. u	

		AND HUMAN SERVICES				FORM): 03/05/2012 / APPROVED) <u>. 0938-0391</u>
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	AULTIPL ILDING		(X3) DATE COMPL	
		245265	B WI	NG		02/	16/2012
	ROVIDER OR SUPPLIER		<u>, , , , , , , , , , , , , , , , , , , </u>	240	FT ADDRESS CITY STATE, ZIP CODE 10 ST FRANCIS DRIVE ECKENRIDGE, MN 56520		
(X4) 1D PREFIX TAG	(EACH DEFICIENC'	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΠX .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DFFICIENCY)	JULD BE	(X5) COMPLETION DATE
	toileting schedule.	I was questioned about R88's She stated she has not gotten had to help another resident	F	315			- VASION GARSON (SP)
	At 10:30 a.m. a nut to wheel R88 to he into bed via hoyer I with urine which ha NA-H verified at the assisted with toileti	sing assistant was observed er room. R88 was transferred ift. R88's brief was saturated d leaked through her pants. at time R88 had not been ng since she was gotten out of m. (3 hours later) and she				<mark>. 1997 -</mark>	1999 - 1999 1999 - 1999 - 1999 1999 - 1999 - 1999 1999 - 1999 - 1999 1999 - 1999 - 1999 - 1999 1999 - 19
	Interviewed. She ve followed and R88 s incontinence every 483.25(h) FREE OI HAZARDS/SUPER The facility must er environment remail as is possible; and adequate supervisi prevent accidents. This REQUIREMENT by: Based on observati failed to maintain an accident hazards in neighborhoods (Ra	FACCIDENT	F	323	St. Francis Home will en that the resident environ remains as free of accide hazards as is possible. power sources for all 6 fireplaces in the neighbor parlors were disconnecte all the switches were tag as "no longer in service" 16-12. A statement has placed in the Fire Marsh Regulatory Compliance stating the fireplaces has	iment ent The orhood ed and gged " on 2- been hal book	3-27-12

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		AND HUMAN SERVICES				FORM	03/05/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	- } · ·	MULTIPLE C	CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		245265	B WI	ING		02/10	3/2012
	PROVIDER OR SUPPLIER			2400 S	ADDRESS, CITY, STATE, ZIP CODE ST FRANCIS DRIVE CKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORH (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	IX5) COMPLETION DATE
Constraint of the second of th	independently mob Findings include: Railways unit Northern Pacific Life Wild Rice River/Re On 2/13/12, at 7:13 within the lounge b and Milwaukee Ro unit did not appear present. However, ventilation grill the touch. No residents that time. At 7:36 p.m. this fir residents were pre: On 2/14/12, at 8:30 appeared to be off the upper black ver the fireplace was v were in the lounge At 10:00 a.m. the fi touch along the upp residents in wheeld	he/Milwaukee Road Line and d River of the North fireplaces b p.m. the fireplace located etween Northern Pacific Line ad Line, within the Railways to be on as no flame was along the upper black fireplace felt very hot to the swere present in the lounge at eplace remained the same, no sent in the lounge. a.m. the fireplace again as no flame was present, yet ntilation grill along the top of ery hot to touch. No residents area. replace remained very hot to ber black ventilation grill. Four hairs were in the lounge area	F	323	been permanently disa not to be activated. R checks will be done to fire places have not be activated. QA&A Con monitor results. Responsible: Plant O Director	andom o assure een mattee to	φ χρ. κ ε 12
	the residents attem wheelchairs.	sest resident was at from the fireplace. None of pted to propel their sidents were in the lounge at				·	
		lace ventilation grill remained					
FORM CMS-2	567(02-99) Previous Versions	Obsolate Event ID COTG1	1	Pacriity IO	00818 If cor	tinuation sheet P	age 18 of 32

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 245265		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B WI	NG		02/16/2012			
	ROVIDER OR SUPPLIER			2400	T ADDRESS CITY STATE ZIP CODE ST FRANCIS DRIVE ECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL \$C IDENTIFYING INFORMATION}	ID PREF TA(Ξ X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFFRENCED TO THE APP OEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa very hot at this time		F	323				
	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.							
	fireplace "hasn't be was brought to the hot to touch. NA-B monitor the fireplac "We wouldn't even	p.m. NA-B stated the en used this winter." NA-B fireplace and verified it was stated there was no way to e temperature. NA-B stated, know it was on." NA-B stated uched the fireplace and no burned.					•	
	never seen the fire	p.m. NA-C stated she had blace on. NA-C stated she idents feel the fireplace and urned,						
	operations (DPO) of lounge between Wi the North. At that ti are terribly hot." The	p.m. the director of plant hecked the fireplace in the ld Rice River and Red River of me, the DPO stated, "They e DPO stated they would be now and added they would put to not use.					. * ·	
	On 2/15/12, at appr 2/16/12, at 8:30 a.m	oximately 8:30 a.m. and on n. the fireplace on the Railway						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 03/05/2012 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1	HULTIPLE ILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245265	B WI	NG		02/1	6/2012	
	ROVIDER OR SUPPLIER			2400	TADDRESS. CITY, STATE ZIP CODE ST FRANCIS ORIVE CKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prei Tag	FIX	FROVIDERS PLAN OF CORRE {EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY}	OULD BE	(X5) COMPLETION DATE	
1		age 19 orthern Pacific Line and the ine was observed to not feel	F	323				
Appensive Appens	verified there were affected.	5 a.m. the unit clerk (UC)-A 19 residents on these areas				$e^{-i\theta} = \zeta$		
	On 2/13/12, at 7:20 between the Soo L Line hall located or was observed to be approximately 3 fee foot deep. It had a the front of it. The f with a 2 inch black touched the black <i>i</i> extremely hot to the greater than 1 seco approximately 15 fee	rthern Line fireplace) p.m. an electric fireplace ine hall and the Great Northern) the Railways Neighborhood a on. The fireplace was at high by 3 feet wide and 1 chain linked screen covering fireplace surround was framed metal strip. The surveyor metal strip which was a touch (could not touch for ond.) 1 resident was sitting aet from the fireplace and as sitting further away in a					* : · ·	
	observed to be on. area as they were a the fireplace remain to the touch. One is wheelchair approxi- fireplace. At 10:33 is extremely hot to the seated approximate	4/12, this fireplace was There were no residents in the eating breakfast. At 9:21 a.m. ned on and was extremely hot resident was sitting in a mately 5 feet from the a.m. the fireplace remained a touch. Six residents were ely 4 feet from the fireplace, ne residents were observed to the fireplace.						
	At 2:24 p.m. on 2/1	4/12, NA-E, NA-H, and NA-F						

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Facility ID 00818

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		AND HUMAN SERVICES			PRINTED: 03/05/2012 FORM APPROVED
STATEMEN	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245265	B WING	~	02/16/2012
NAME OF F	ROVIDER OR SUPPLIER	d	STREE	T ADDRESS, CITY STATE ZIP C	
ST FRAM	ICIS HOME		1	ST FRANCIS DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPLETION E APPROPRIATE DATE
F 323	Continued From pa	age 20	F 323		
	stated they had ner were not sure how had not seen any r fireplace. At this sa noticed the fireplace	ver turned on the fireplace and it worked. They added they esidents get close to the ime time, NA-G stated she hav e running on Sunday morning hought it had been fixed and	i d		
an a	interviewed at 2:11 the staff turned the added, "I don't real they are supposed are turned off even there was not a wa surface temperature	nt operations (DPO) was p.m. on 2/14/12, and stated, fireplaces on and off, and he remote controlled. The DPO ly know much about those, to check and make sure they y evening." The DPO added y to monitor the fireplaces res. The DPO stated the			
	a standard prevent the monitoring of the thought the nursing On 2/14/12, at 2:38 Quality and Clinical confirmed the nursi	rtment did not have a policy or ative maintenance program fo be fireplaces, but added he department may have one, p.m. registered nurse (RN) I Financial Coordinator ing department did not have a nd monitoring of the laces.	ſ		
• • • • • •	Railways sides A a on Railways A mea Fahrenheit, and the measured 168 deg. verified that these r and immediately tu pulling out the switc	4/12, the DPO tested the nd B fireplaces. The mantel sured 178 degrees e mantel on Railways B rees Fahrenheit. The DPO measurements ware not safe rined both fireplaces off by ches that connected to the DPO further added, "We did that hot."			
ORM CMS.20	67(02-99) Previous Versions	Obsolete Event ID COT	244 Looks][B1800 CI	continuation sheet Page 21 of 32

Facility ID: 00818

If continuation sheet Page 21 of 32

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		HAND HUMAN SERVICES			FOR	D: 03/05/2012 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245265	B WING	مىسىدىن بى	02/	16/2012
	PROVIDER OR SUPPLIER		2	REET ADDRESS, CITY STATE ZIP CODE 400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) 10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	Continued From p	age 21	F 323			
	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					
.**					가 있 아름 한	l ys ar orae. ChinteA
						n to an Art
	places.					
	fireplaces had bee	7 p.m. NA-N stated the n on during the Christmas isure how to turn it one.			· · -	یوند میدیش د ایار چراف م اینان
	fireplaces on the P were not used. Sh equipped with a co	0 p.m. RN-B stated the trairie Meadow Neighborhood he stated the fireplaces were ontrol panel behind the metal wottom of the fireplace which es 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.					
	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356	St. Francis Home's Nur Staff Information will b		3-27-12	
	a daily basis: o Facility name. o The current date o The total number by the following ca unlicensed nursing	acility name.		posted with the required information and at a hei that residents can view the Staff Coordinator M through Friday. On the weekends, the Charge N	ight it by Ionday	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID COTG11 Facility ID 00818

If continuation sheet Page 22 of 32

		AND HUMAN SERVICES					APPROVE 0938-039		
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER		ULTIPL LDING		(X3) DATE SURVEY COMPLETED			
		245265	B WI	۱G	02/16/2012				
	PROVIDER OR SUPPLIER	A		240	ET ADDRESS CITY STATE ZIP CODE 00 ST FRANCIS DRIVE RECKENRIDGE, MN 56520				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) Completio Date		
F 356	Continued From pa	age 22	F	356	Fastoria		_		
	vocational nurses (- Certified nurse o Resident census The facility must po specified above on of each shift. Data o Clear and readat o In a prominent pl residents and visito The facility must, u make nurse staffing for review at a cost standard. The facility must m staffing data for a n	ctical nurses or licensed (as defined under State law), e aides. - - - - - - - - - - - - - - - - - - -			 will be responsible for required staffing form process was implement 18-12. Quality assurated monitoring put in place be completed by licent QA&A Committee to results. Responsible: DON 	s. This new ited on 2 nce e and will sed staff.			
	This REQUIREMEI by: Based on observa review, the facility f nurse staffing inform and at a height that	NT is not met as evidenced tion, interview, and document alled to post the required mation with the correct date t residents could view it. This itential to affect all 112							
· .	Findings Include:								
	the nurse staffing h board next to the S	ur at 12:45 p.m. on 2/13/12, ours were posted on a bulletin ocial Service Department. The ng was dated for 2/10/12,							

FORM CMS-2567(02-99) Pravious Versions Obsolete

Facility ID 00818

If continuation sheet Page 23 of 32

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		_	FORM	03/05/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILO	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245265	8 WINC	· · · · · · · · · · · · · · · · · · ·	02/1	6/2012
	IOVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE. ZIP (2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	iD PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Continued From pa (Friday) and at a h view it.	age 23 eight where residents could not	F 31	56		
	indicated the nursi posted at 10:00 a. coordinator "except	Hours Policy dated 1/12, ng staff hours were to be m. daily by the staffing it on Friday, Saturday, and a posted related to the fact that or works M-F."			ی ۲۲۹ می ۱۹۹۰ - ۱۹۹۵ ۱۹۹۰ - ۱۹۹۵ - ۱۹۹۵ ۱۹۹۰ - ۱۹۹۹ ۱۹۹۰ - ۱۹۹۹ ۱۹۹۰ - ۱۹۹۹ ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹ - ۱۹۹۹	ti s Ali s Cu Inter Antifici Inter Antifici
	a.m. on 2/16/12, ve were incorrect and to view. She stated post the nurse stat daily. She also sta Saturday and Sund hours, however, th post the nurse stat weekends.	he Staffing Coordinator at 8:30 erified the nurse staffing hours placed too high for residents I twas her responsibility to fing information by 10:00 a.m. ted the nurse staffing hours for day were placed behind Fridays ere was no staff assigned to fing information for the		· · ·		
\$\$=F	The facility must - (1) Procure food fr considered satisfa authorities; and (2) Store, prepare, under sanitary con	E/SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food	F 31	St. Francis Home wil store, prepare, distrib serve food under sani conditions. Educatio provided on 2-22-12 3-7-12 to licensed sta be provided to NA-R 12 regarding washing before and after conta residents and proper g technique which will	ute and tary n was to FNS staff, ff and will 's on 3-21- g hands act with gloving	3-27-12
	by: Based on observa	tion, interview, and document				
ORM CMS-256	J7(02-99) Previous Version	s Obsolete Event ID, COTG1	1	Facility ID: 00818	If continuation sheet	Page 24 of 3

		H AND HUMAN SERVICES				FORM	03/05/2012 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1.		PLE CONSTRUCTION	(X3) DATE \$U ÇOMPLE	
		245265	B WI	NG		02/10	3/2012
	PROVIDER OR SUPPLIER			24	EET ADDRESS CITY, STATE ZIP CODE 400 ST FRANCIS DRIVE RECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAI	FIX 👘	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE GROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	foods in a sanitary hand hygiene prio the distribution of (Lady Slipper, Will practice had the p residents residing Findings include: Lady Slipper/Wild At 5:35 p.m. on 2/ was observed to h dining room, Lady in it. The second 14 residents waitin At 5:45 p.m. cook dishing plates for dining room. As s reached directly in gloved hand and y residents. She als dinner rolls and pl her gloves hand. At 5:50 p.m. cook cards located in a counter next to the returned to the ste gloves and again the residents. Shi the dinner rolls an same gloved hand At 5:52 p.m. the d	failed to ensure staff served manner related to appropriate r to touching food items during food in 3 of 3 dining rooms d Flower, Railways). This otential to affect all 112 in the facility. Flower 13/12, the Prairie Meadows unit have two dining rooms. The first Slipper had 15 residents sitting dining room, Wild Flower, had ng for their meal. B donned gloves and began the residents in the Lady Slipper the dished the meals, she ito the steam table with her bicked up baked potatoes for ao reached into the container of cked up a the dinner roll with B flipped through the dietary flip folder (kardex) resting on a e steam table. Cook-B then ham table wearing the same began dishing up the meals for e was observed to directly touch d the baked potatoes with the	F	371	cross-contamination. Rat observations will be con- Infection Control Nurse designees. Data will be s monthly FNS, NA-R and staff meetings and quarte QA&A. QA&A Commi monitor results. Responsible:, DON	ducted by or hared at I licensed erly at	
ORM CMS-2	the meals for the 7	·····	, 1	Гас	ility ID 00818 If con	linvation sheet F	age 25 of 32

		I AND HUMAN SERVICES				FOR	D: 03/05/2011 MAPPROVED D: 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLI LDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245265	B WI	IG		02/	16/2012
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				240	ET ADDRESS. CITY STATE ZIP CODE 0 ST FRANCIS DRIVE ECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	juld be	(X5) COMPLETION DATE
	dietary aide (DA)-C and the meal cart t Cook-B and DA-C when they moved t cords for the steam At 5:54 p.m. cook-I the residents in the She continued to w picked up the bake with her gloved har residents in the WI their evening meal.	r dining room. Cook-B and then wheeled the steam table to the Wild Flower dining area. did not remove their gloves he carts and the electrical	۴.	371			
	observed in the La breakfast meal was the staff members the residents. At 8:41 a.m. nursin preparing a meal for gloves and placed touched the toaster then went to the free bag of sausages, o removed three sau sausages on a plat closed the door, sta replaced the bag ba opened a drawer, r it with fruit. She plat then went to a sma bolled eggs from the	5/12, the breakfast meal was dy Slipper dining room. The s an open breakfast in which would prepare the meals for g assistant (NA)-J began or a resident. She donned bread into a toaster. She r with her gloved hand. She ezer and removed a zip lock pened the bag, and then sages. She then placed the e, opened the microwave, arted the microwave and ack in the freezer. She then emoved a small bowl and filled aced the fruit cup on a tray and Il steam table and removed a ie container and proceeded to placed the pealed egg on a			· · · · · · · · · · · · · · · · · · ·		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID 00818

If continuation sheet Page 26 of 32

		AND HUMAN SERVICES				FORM): 03/05/2012 // APPROVED): 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		MULTIPLE CO	INSTRUCTION	(X3) DATE COMPL	SURVEY
		245265	B WI	NG		02/	16/2012
	PROVIDER OR SUPPLIER	<u>Lander</u> , <u>Kantan</u>		2400 \$1	DDRESS CITY STATE ZIP COL FRANCIS DRIVE (ENRIDGE, MN 56520	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tac	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	buttered it, and ren microwave. She a the resident's plate gloved hands. At & gloves, picked up t resident on the unit At 8:44 a.m. NA-K hand and placed a She then donned a the steam table and pealed the egg and opened a drawer, r with mixed fruit. At toast from the toas plate and cut the e She then delivered dining room. At 9:09 a.m. NA-K bead in the toaster, she walked over to kitchen counter. Si	bread from the toaster, hoved the sausages from the tranged each of the items on touching the food with her 1:43 p.m. she removed her the tray and delivered it to a donned a glove on her left slice of bread into the toaster, second glove, reached into d removed a boiled egged, i placed it on a plate. She ther emoved a small bowl, filled it 8:45 a.m. she removed the ter, buttered it, placed it on the gg with the same gloved hand the meal to a resident in the donned gloves prior to placing She kept her gloves on as a resident sitting at the ne talked to the resident,	1	371		·	
	then returned to the bread with her sam butter and jelly to th another resident in observed to remove	It's hand and the counter. She toaster and removed the e gloved hands. After adding te toast, she delivered it to the dining room. She was a her gloves after she had to the resident in the dining	8				
	Railways						
	room at 5:00 p.m. c	ation in the Railways dining in 2/13/12, 16 residents were ir. DA-B donned a pair of					
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID COT	G11	Facility IO (00B18 If cc	ontinuation sheel	Page 27 of 32

	MENT OF HEALTH							FORM	APPROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SEF (X1) PROVIDER/SUPPI IDENTIFICATION N	IER/CLIA		IULTIPLE CO	ONSTRUCTION		(X3) DATE S COMPLE	
		24526	5	BWI	NG		02/16/2012		
NAME OF F	ROVIDER OR SUPPLIER	1				DORESS CITY STA		.	
ST FRAM	CIS HOME					FRANCIS DRIVE KENRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	id Pref Tag	-IX	(EACH CORRECT CROSS REFERENC		ULD BE	IX5) COMPLETION DATE
F 371	Continued From pa gloves without was 2 pieces of bread fi them into the toaste toasting, DA-B ope took out a plate, sh drawer and took ou gloved hands DA-E toaster and procee brought it to a resid sanitize her hands meal service. During observation approximately 5:13 wearing gloves. NA with buttering their to their baked potal	hing her hands firs from the bread bag er. While the bread ned the upper cupl e then opened the it a knife. With the B removed the bread ded to butter it and lent. DA-B did not v during any of the o of the same meal p.m. NA-I was obs I was assisting the dinner rolls and ap	and placed was poard and silverware same d from the then wash or bserved at served e residents plying butter	F	371		·· · · · · · · · · · · · · · · · · · ·	$f \in D_{1}^{*}$	- (1948) (194) 2040 - Copert 1940 - Copert 1
	butter on the floor, gloved hands and p continued to assist their rolls and potat contaminated glove picking up the butte	picked it up with the blaced it on the tab the residents with coes, NA-I did not n as or sanitize her h	e same le and buttering emove her ands after						
	On 2/15/12, at 11:2 DA-A donned glove wash hands or use baked beans to res	es, but was not obs hand sanitizer pric	erved to				<u> </u>	• •	- - -
	At 11:33 a.m. cook the steam table with the same gloved ha handle buns. Cook fries and buns with 19 residents on tha	h her gloved hand, and to scoop steak t-A continued to ha the same gloved h	then used fries and ndle steak						
	At 11;48 a.m. cook	· · · · · · · · · · · · · · · · · · ·				• • • • • • • • • • • • • • • • • • •			
ORM CMS-2	567 (02-99) Previous Versions	Obsolete	Event ID COTG11		Facility ID	00816	If contin	uation sheet	Page 28 of 32

		AND HUMAN SERVICES				FORM	03/05/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IUI TIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245265	B WI	NG		02/1	6/2012
	ROVIDER OR SUPPLIER			24	EET ADDRESS CITY, STATE ZIP CODE 00 8T FRANCIS DRIVE RECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) Completion Date
F 371	Continued From pa	iae 28	F	371			
	handle the buns or she used gloved ha utensils because it	fries generally." She stated ands instead of tongs or was easier to get the buns ght serving size of the fries.	·				1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
	nutritional services have either used ha prior to serving resiventified after cook- steam cart, she she hands or used hand gloves prior to serv stated the policy dir touch food the resid added if staff have	0 p.m. the director of food and (DFNS). stated staff should and sanitizer or washed hands ident foods. The DFNS A touched the paper on the build have either washed her d sanitizer and changed her ing more food. The DFNS rects for staff to use gloves to bent is going to eat. The DFNS touched cabinets or other dirty I to remove those gloves, and			· · · · · · · · · · · · · · · · · · ·		
	either wash or use to handle food. The facility policy til 5/10, directed staff gloves, after remov with objects and eq immediate vicinity.	hand rub, then reapply a glove led Hand Hygiene reviewed to wash hands before donning ing gloves, and after contact upment in the resident's	E	6 .4.4			
\$\$=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infer (a) Infection Contro The facility must es Program under white	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.	F.	441	St. Francis Home will commaintain an infection control program designed to provisafe, sanitary and comfort environment and to help p the development and trans of disease and infection. A licensed nurses attended shon March 6, 7, 13 and 14,	rol de a able revent mission All kills lab	3-27-12
ORM CMS-25	(1) mvestigates, co. 	مربع میں بین میں اور		Face			age 29 of 3

QA&A Committee to monitor results.

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	TH AND HUMAN SERVICES	·		FORM OMB NO.	
TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING		(X3) DATE SU COMPLE	
	245265	B. WING		02/1	5/2012
NAME OF PROVIDER OR SUPPLIES ST FRANCIS HOME	3	240	ET ADDRESS CITY. STATE ZIP CODE 10 ST FRANCIS DRIVE ECKENRIDGE, MN 56520		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
 should be applied (3) Maintains a reactions related to (b) Preventing Sp (1) When the Infedetermines that a prevent the spreasisolate the reside (2) The facility muscle different contact will (3) The facility muscle for the spreasisolate and the spreasisolate is professional practices (c) Linens Personnel must here 	procedures, such as isolation, I to an individual resident; and acord of incidents and corrective infections. pread of Infection eresident needs isolation to a of infection. The facility must int. ust prohibit employees with a sease or infected skin lesions ct with residents or their food, if transmit the disease. Ust require staff to wash their direct resident contact for which indicated by accepted	F 441	which covered wound ca infection control. This to will be discussed again a licensed staff meetings of 23&26, 2012. NA-R's we have infection control the on 3-21-12. Quality ass monitoring put into place will be completed by the Infection Control Nurse, will be shared at monthl and licensed staff meetin Data will also be reported QA&A. QA&A Commi- monitor results. Responsible: DON	opic at the on 3- will aining urance e and Data y NA-R ngs. ed at	
by: Based on observ review, the facility washing while pro	ENT is not met as evidenced ation, interview and document failed to ensure proper hand oviding care for 1 of 4 (R88) ample observed to receive		· · ·		
Findings include:					

		HAND HUMAN SERVICES				FORM	: 03/05/2012 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE S COMPLE	
		245265	8 WIN	G	аранан алан алан алан алан алан алан ала	02/1	6/2012
	ROVIDER OR SUPPLIER			2400	T ADDRESS, CITY STATE, ZIP CODE ST FRANCIS DRIVE CKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	JULU BE	(X6) COMPLETION DATE
	prior to providing p On 2/16/12, at 10: was observed to w Licensed practical room. R88 was tra R88's brief was sa applied gloves and removing the brief She then cleansed removing her glove pick up the Duoder pressure ulcers) pa and then used the dry the coccyx area over the pressure of gloves. With the sa grabbed a roll of ga resident's drawer a assistant. She ther without washing he clothing, bedding a point LPN-C used disinfect her hands verified after the o have changed glov Duoderm.	ige gloves and/or wash hands ressure ulcer cares for R88. 30 a.m. a nursing assistant heel R88 to her room nurse (LPN)-C was also in the nsferred into bed via hoyer lift. turated with urine. LPN-C I proceeded to assist with and providing perineal care. the pressure ulcer. Without as, LPN-C then proceeded to rm (dressing for treatment of ackage (had pre-cut pieces) soaker pad under R88 to pat a. LPN-C applied the Duoderm ulcer with the contaminated ame gloved hands LPN-C arbage bags from the and passed them to the nursing nemoved her gloves and er hands proceeded to adjust and the hoyer sling. At that alcohol based foam to a prior to leaving the room. She bservation that she should res prior to applying the	F 4	41			
	the following: Hand after touching bloo excretions, and con not gloves are worn are removed; and avoid transfer of m residents, personn	Policy dated 2/12, indicated I hygiene must be performed d, body fluids, secretions, ntaminated items, whether or n, and immediately after gloves when otherwise indicated to icroorganisms to other el and/or the environment. ut not limited to: before					

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID COTG11

Facility ID 00818

If continuation sheet Page 31 of 32

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLI A BUILDING	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETEO
		245265	B WING		02/	16/2012
	ROVIDER OR SUPPLIE	R	STREE 2400 BRI	······		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ECKENRIDGE, MN 56520 PROVIDER'S PLAN OF CO (EAGH CORRECTIVE ACTIO) CROSS-REFERENCED 10 THE DEFICIENCY)	V SHOULD BE	(XS) COMPLETIC DATE
F 441		page 31 of any kind, after touching ce that may have been	F 441	<u>, , , , , , , , , , , , , , , , , , , </u>		

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

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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) \rightarrow Hui us additional education open phone call - 4/2/12 @3⁰⁵/m 10 C date tremuens 3/27/12 of

Becky Johnson DNS Mary Helland VP of Health Care Services

			7526	,5021	PRINTED: 03/05/2012
		AND HUMAN SERVICES			OMB NO. 0938-0391
STATEMENT	IS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION 02 - MAIN BUILDING	(XS) DATE SURVEY COMPLETED
		245286	B. WING		02/15/2012
NAME OF P	ROVIDER DR SUPPLIER	L		T ADDRESS, CITY, STATE, ZIP CODE	
ST FRAN				ST FRANCIS DRIVE ECKENRIDGE, MN 55520	
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K 000		rs	K 000'	DEME	
2	FIRE SAFETY				
03, 28,	ALLEGATION OF DEPARTMENT'S / SIGNATURE AT T	COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST HS-2567 WILL BE USED AS F COMPLIANCE.	ì	MAR 2 2 MN DEPT. OF PUI STATE FIRE MARS	BLIC SAFETY
DC	UPON RECEIPT C AN ONSITE REVIS BE CONDUCTED SUBSTANTIAL CC REGULATIONS H	DF AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN TITH YOUR VERIFICATION.		POC 04 0 3-206-12	:
2.16-2012	Minnesota Departm time of this survey Building was found with the requireme Medicare/Medicaid 483.70(a), Life Saf edition of National	Survey was conducted by the nent of Public Safety. At the St Francis Home 01 Main I not in substantial compliance ints for participation in I at 42 CFR, Subpart sty from Fire, and the 2000 Fire Protection Association 101, Life Safety Code (LSC), eaith Care.		TS /	
Ē	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY	: 1		
Т. ШX	PATRICK SHEEH SUPERVISOR STATE FIRE MAR 444 CEDAR STRE ST PAUL, MN 551 Email: pat.sheehar	SHAL DIVISION ET, SUITE 145 01-5145	×		9
LABORATOR	Y DIRECTORD OR PROV	DEASUPPLIER REPRESENTATIVES SIGN	ATURE	TITLE	(X0) DATE 3-21-12
_4	PAINS	epin		President/CE0	

Any deficiency statement ending with an esterisk (") 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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TATEMENT	of Deficiencies F Correction	& MEDICAID SERVICES	A. BUILI	DING	ONSTRUCTION 02 - MAIN BUILDING	(X3) DATE 5 COMPL	ETEP
		245265	B. WING			02/	16/2012
	ROVIDER OR SUPPLIER		1	2400 5	ADORESS, CITY, STATE, ZIP CO IT FRANCIS DRIVE IKENRIDGE, MN 56520	DE	
(X4) ID PREFUX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X3) COMPLETION DATE
K 000	Continued From p Fax Number 651-2	-	KO	00			22
- C.N.C.					a source of the second distance of the second	MCAR	
a tala siti a na si	1. A description of to correct the defin	what has been, or will be, done		ļ	2005.00 3005.00	0125 65-82 62157	17. 4 COL M
	, 2. The actual, of p	roposed, completion date.		Ĩ	a a sua como		W.C.A.
in the second	responsible for co	or title of the person rrection and monitoring to rance of the deficiency.			er er Marse h A erhane		
	Healthcare Camp 1-story building, w determined to be separated from St	a part of the St Francis us. It was built in 2005, is a ithout a basement and was Type V (111) construction, it is Francis Healthcare Center with s and is divided into 4 amoke fire barriers.			2 K 12 K Ř	a sa ang ang ang ang ang ang ang ang ang ang	
	automatic fire spri response heads a NFPA 13 Standar Systems 1999 ed.	a is completely protected by nkler system, with quick and installed in accordance with d for the installation of Sprinkler tion. The facility has a manual with smoke detectors			2 2 X 2 72		
	throughout the co the corridor and c accordance with I Alarm Code" 1999 automatic fire det system and all sid	rridor system, in areas open to ommon areas installed in NFPA 72 "The National Fire 9 edition. Hazardous areas have ectors that are on the fire alarm eping rooms have emoke im outside the rooms and at the			3 3 453 3 5 8 5	≈ 3 <i>₫</i> 3	19 ⁷⁵
	- nurse's station the	at serves that room in he Minnesota State Fire Code					

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TATEMENT	OF DEFICIENCIES	8. MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: 245265	(X2) MU A. BIVIL 8. WIN	DING 0	COM	E SURVEY PLETED 2/16/2012
	ROVIDER OR SUPPLIER			24	EET ADDRESS, CITY, STATE, ZIP CODE 00 ST FRANCIS DRIVE RECKENRIDGE, MN 56520	
(XA) ID PREFIX TAG	ICACH DERICICHC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	The facility has a c census of 113 at t	age 2 prveyed as one building. capacity of 120 beds and had a he time of the survey. at 42 CR, Subpart 483.70(4) is	K	, 000 !		
K 069 SS≂F	NOT METas evide NFPA 101 LIFE S Cooking facilities with 9.2.3. 18.3	anced by: AFETY CODE STANDARD are protected in accordance .2.6, NFPA 96	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	3-27-12
	An interview with Department of Ha cooking is being of kitchen, that is no section 1-3.1. This the ignition of a bi develop and allow	various staff and the Minnesota aith Surveyors revealed that lone outside of the main t in accordance with NFPA 96 a deficient practice could allow uild-up of grease that could v a fire to spread which would all the residents, staff and			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	
	2012, between 10 Interviews with the cletary staff (M ar eggs were being i then a tablespoor cooking spray in a neighborhood kito and the kitchens	g the facility tour of February 15, 35 am and 12:30 pm, a MDH staff (PK) and facility and C) revealed that occasionally tried in a small amount (less a) of butter or a small amount of all six of the residential style thens, during the breakfast hour are not separated from the or do they have hood			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.	

FORM CMS-2567(02-99) Previous Versions Obsolate

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If continuation sheet Page 3 of 4

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER		1 2	REET ADDRESS, CITY, STATE, ZIP CODE MOD ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
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K 069	Continued From pa suppression system NFPA 98 as requir	ns installed in accordance with	K 069	Responsible: Plant Oper Director	rations
: (PA.)	findings during the	Intenance (SM) verified these to a facility.	K 072		PRINTED: 00/05/201 PCRIA DEPROVE OVIS NO 0956/039
SS=C	Means of egress a of all obstructions use in the case of furnishings, decord exits, access to, eg	re continuously maintained free, or impediments to full instant fire or other emergency. No ations, or other objects obstruct gress from, or visibility of exits.		Snow was removed on 2 12. Our snow removal 1 states that these areas w checked on a daily basis snow buildup. We did a	ill be
- 2 - 4 - 4 	7.1.10			complete retraining with maintenance staff on ch these doors daily even it	ecking
5 ×2	Observations of a revealed that three and do not comply Safety Code" 2000 This deficient prac- residents, staff am	Is not met as evidenced by: It the exits and exit discharges exit discharges are obstructed with NFPA 101 "The Life) edition (LSC) section 18.7.2.3. tice could negatively affect all d visitors that need to be through these exits.		 is no new snowfall on 2 12. These accumulation snow were a result of sn blowing in even though not snowed recently. Awareness was made w 	-16- ns of iow it had
	between 10:35 arr the three north exi Meadows and Riv covered with show	tour of February 15, 2012, and 12:30 pm, revealed that t discharges, from the Prairle ar Walk Neighborhooda were what had blown in.		staff on monitoring exit doors during winter mo A daily checklist for do checks was implemente Data will be reported to OA&A	nths. or d.
2311		aintenance (SM) verified these tour of the facility.	e.	Responsible: Plant Operations Director	



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 Jameon

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

Minneso	ta Department <u>of I</u>	lealth		¥\$334	an an Spansa a san ar		ED: 03/05/2012 RM APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A, BUILDIN B. WING	RECEIVED ple construction g MAR 2.2 2012		TE SURVEY MPLETED
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2 000	Initial Comments			2 000			
	****ATT	ENTION*****					
	NH LICENSING	G CORRECTION ORD	ER				
	144A.10, this corr pursuant to a sur- found that the def	th Minnesota Statute, s rection order has been vey. If, upon reinspect ficiency or deficiencies	issued ion, it is cited				
	not corrected sha with a schedule o	rected, a fine for each Il be assessed in acco f fines promulgated by partment of Health.	rdance				
	corrected requires requirements of the number and MN I When a rule contribution comply with any contribution lack of compliance re-inspection with result in the assess	whether a violation has s compliance with all he rule provided at the Rule number indicated ains several items, failu of the items will be cons e. Lack of compliance any item of multi-part ssment of a fine even i during the initial inspec	tag below. ure to sidered upon rule will f the item				
	that may result fro orders provided th the Department w	a hearing on any asse om non-compliance wit nat a written request is rithin 15 days of receip nent for non-complianc	h these made to t of a				
	Department's stat the following licen corrections are co make a copy of th original to the Min Division of Compl	NTS: and 16, 2012, surveyor if, visited the above pro- ising orders were issue ompleted, please sign a nese orders and return inesota Department of iance Monitoring, Licer	ovider and ed. When and date, the Health,		Minnesota Department of documenting the State L Correction Orders using Tag numbers have been assigned to Minnesota s for Nursing Homes.	∟icensing ⊨federal softwar າ	
(partment of Health	Wehn			TITLE Proof dont /CEC		(X6) DATE
		/IDER/SUPPLIER REPRESEN			President/CEC		3-21-12
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
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2 000		ım; 705 5th St. N.W.,	Suite A,	2 000	The assigned tag number far left column entitled "ID Prefix Tag." The state stat and the corresponding text of the state statute/rule out is listed in the "Summary Statement of Deficiencies" replaces the "To Comply" p of the correction order. The includes the findings which are in violation of the after the statement, "This Rule is not met as evidence Following the surveyors fin the Suggested Method of C the Time Period For Corree PLEASE DISREGARD TH THE FOURTH COLUMN V STATES, "PROVIDER'S PLAN OF C THIS APPLIES TO FEDEF DEFICIENCIES ONLY. TH APPEAR ON EACH PAGE THERE IS NO REQUIREN SUBMIT A PLAN OF COR VIOLATIONS OF MINNES STATUTES/RULES.	tute/rule number to f compliance column and portion nis column also e state statute ed by." dings are Correction and ction. E HEADING OF WHICH CORRECTION." RAL IIS WILL E. MENT TO RECTION FOR	
2 550	Resident Assessme			2 550			
	home must examin quarterly and must comprehensive ass	f assessments. A nu- le each resident at lea revise the resident's sessment to ensure the y of the assessment.	ast he				

Minneso	ta Department of He	ealth				FORM	APPROVED
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	by: Based on interview facility failed to ass of 1 resident (R32) behaviors. Findings include: R32's diagnoses in dementia. The qua (MDS) dated 11/28 cognitive impairme assistance with all MDS also revealed concentrating, beca	ame easily annoyed ved wandering behavi	ew, the viors for 1 ering nd i Set ith extensive g. The with				
	assessment of the including: when the interventions to dec evaluation of the be At 1:30 p.m. on 2/1 stated R32 would v rooms and would ta the rooms. She sta in another resident out of the room. SI to redirect at time. other residents on r R32's behavior and concerns related to time, she reviewed record did not conta assessment of the	5/12, registered nurs vander into other resi ake the personal item ated when the staff n room, they are to as he stated R32 was vers She stated she was us the unit were bothered was not aware of ar o R32's behaviors. A R32's record and vers ain a comprehensive wandering behaviors	, and an e (RN)-B ident ns from otice R32 sist her ery difficult unaware ed by ny family t that rified the				
	-	5/12, quality of life ai	de-A				
linnesota D	epartment of Health						

Minnesc	ta Department of He	ealth				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE S COMPLI	
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2 550	other resident room aware of the behave residents. She stat to engage the reside was wandering, but At 2:30 p.m. on 2/1 (LSW)-A stated she wandering behavio which she wandere She stated some of concerns related to behaviors, but she concerns to determ displaying the behave interventions were behaviors. She very	age 3 are R32 would wandens, but stated she war ior bothering any of t ted she would at time lent in an activity whe t it didn't always work 6/12, licensed social e was aware of R32's rs, including behavior d into other resident ther resident's wander had not investigated nine which resident wavior to ensure appro- in place to decrease erified she had not co havior assessment of	s not the other es attempt en she c. worker s in rooms. ade ing the ras priate the mpleted a	2 550			
2 565	administrator and the designee could procedures to ensure assessments are concerned on the ducate all appropriate and the develop monitoring compliance. TIME PERIOD FOR (21) days.	THOD OF CORRECT he director of nursing develop policies and ure comprehensive ompleted at the time e DON or her designer on or her designer on or her designer systems to ensure of R CORRECTION: Tw 5 Subp. 3 Comprehe	g (DON) or of the ee could blicies and could ongoing venty one	2 565			
Minnesota D STATE FOR	epartment of Health			6899		16 11	in the state of the state
JIAIEFUR	IVI			(COTG11	ir continuat	ion sheet 4 of 29

Minneso	ta Department of He	ealth				FORM	APPROVED
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2 565	Continued From pa	age 4		2 565			
	Subp. 3. Use. A c	omprehensive plan o I personnel involved i					
	by: Based on observat review, the facility f assistance with rep according to the pla	ent is not met as evi ions, interview and de ailed to provide timel positioning and toiletir an of care for 1 of 2 (mple who required as	ocument y ng R88)				
	Findings include:						
		led assistance with to ding to the plan of ca					
	risk for skin breakd and incontinence.	29/09, indicated R88 own due to decrease Interventions include nours, and check for 2 hours.	ed mobility				
	On 2/15/12, R88 was observed from 7:30 a.m 10:00 a.m. (2.5 hours) to be positioned on her right side in bed and was not provided assistar with repositioning or toileting. Nursing Assistar (NA)-H verified findings.		on her ssistance				
	10:30 a.m. (3 hours to be positioned in provided assistance R88 was observed	as observed from 7:3 s) her wheelchair and w e with reposition or to to be saturated with NA-H verified finding	vas not bileting. urine				
Minnesota D	R88 was observed	to be saturated with	urine				

Minnesc	ta Department of He	ealth				FORM	APPROVED
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2 565	Continued From pa	age 5		2 565			
	The administrator of system to educate system to ensure s directed by the write TIME PERIOD FOR	THOD OF CORRECT or designee could dev staff and develop a r taff are providing car ten plan of care. R CORRECTION: Tr	velop a nonitoring re as				
2 900	(21) days. MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pi	ressure	2 900			
	comprehensive res of nursing services	sores. Based on the ident assessment, the must coordinate the nursing care plan which	ne director				
	without pressure s pressure sores unle condition demonstr	to enters the nursing ores does not develo ess the individual's o rates, and a physiciar they were unavoidab	op clinical n				
	receives necessar	who has pressure some y treatment and serv revent infection, and veloping.	ices to				
	by: Based on observat interview, the facilit treatment to promo	ent is not met as evi ion, document review y failed to provide ap ite healing of pressur idents in the sample	v and propriate e ulcers				
	Findings include:						
	epartment of Health						
STATE FOR	M			⁶⁸⁹⁹ (COTG11	If continuat	ion sheet 6 of 29

Minneso	ta Department of He	ealth					APPROVEL
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
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2 900	2 900 Continued From page 6			2 900			
	thickness loss of de open area usually of not provided timely and dressings were of care. The Full Minimum I 10/31/11, indicated total assistance wit (ADLs), was at risk ulcers and had sev The quarterly MDS indicated the same plan of care (POC) was at risk for skin mobility and inconti to monitor for redne	ge 2 pressure ulcer ermis presenting as over a bony promine assistance with repre- e not applied according Data Set (MDS) com R88 required exten h all activities of dail for development of ere cognitive impair completed on 12/30 as the previous MD dated 1/29/09, indic breakdown due to d inence. Intervention ess, keep clean and devices in wheelchail very 2 hours.	a shallow nce) was ositioning ing to plan hpleted on sive to y living pressure ment. 0/11, IS. The cated R88 lecreased s included dry,				
	The nursing progre	ess notes indicated:					
	area and treatment 2/12/12 Treatment	e - Dr. (name) notifie to the left buttock Orders - Monitor Sta 0800. D/C (discontin	age II PU				
	The Skin and Wou	nd Flow Sheet indica	ated:				
	Duoderm (dressing ulcers) applied. Arg 2/11/12- Measurer	to coccyx. 1 cm by for treatment of pre ginaid added for heal ment same cm. Using NCC (ba	essure ling.				

ota Department of He	ealth					APPROVED
IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	G	– COMPL	
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ROVIDER OR SUPPLIER						
NCIS HOME						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	age 7		2 900			
The Temporary Ca	re Plan dated 2/9/12	indicated:				
needed (prn). Repo every 2 hours	S.	as				
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						
appropriate reposit 2/11/12 for w/c doc PU to the inner left tolerate an every 2 Refer to skin risk a to POC. A Tissue 2/10/12 for bed also	ioning schedules) da sumented R88 had a buttocks and was ab hour repositioning so ssessment. Add Roh Tolerance Testing fo o indicated an every	ted stage 2 ble to chedule. o cushion rm dated				
risk) dated 2/11/12	, documented a scor					
lying on her right si remain positioned of 10:00 a.m. when N into her room to pro stated the last time incontinence or rep approximately 7:30 R88 gets up earlier that today." Perinea stage 2 pressure up	de. R88 was observe on her right side in be ursing Assistant (NA ovide morning cares. R88 was checked fo oositioned was at 0 a.m NA-H added u but "other priorities p al care was provided lcer (PU) was observe	ed to ed until)-H went NA-H or usually orevented and a ved to the				
	PROVIDER OR SUPPLIER VCIS HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The Temporary Ca Stage II PU - Duod needed (prn). Repo every 2 hours Follow skin/wound Treatment orders: 2/11/12 - chart s/w coccyx every Tuess 2/10/12 - Vit C A Tissue Tolerance appropriate reposit 2/11/12 for w/c doo PU to the inner left tolerate an every 2 Refer to skin risk a to POC. A Tissue 2/10/12 for bed als repositioning scheo A Braden Scale (to risk) dated 2/11/12 which would indica On 2/15/12 at 7:30 lying on her right si remain positioned of 10:00 a.m. when N into her room to pro- stated the last time incontinence or rep approximately 7:30 R88 gets up earlier that today." Perinea stage 2 pressure u left of the coccyx a	OF CORRECTION IDENTIFICATION NU OD818 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM/ Continued From page 7 The Temporary Care Plan dated 2/9/12 Stage II PU - Duoderm q (every) 7 days needed (prn). Repo every 2 hours. Follow skin/wound guidelines. Treatment orders: 2/11/12 - chart s/w (size/width) stage II I Coccyx every Tuesday - monitor stage II 2/10/12 - chart s/w (size/width) stage II I Coccyx every Tuesday - monitor stage II 2/10/12 - Vit C A Tissue Tolerance Testing form (used appropriate repositioning schedules) da 2/11/12 for w/c documented R88 had a PU to the inner left buttocks and was ab tolerate an every 2 hour repositioning sc Refer to skin risk assessm	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00818 00818 PROVIDER OR SUPPLIER STREET ADD 2400 ST F BRECKEN NCIS HOME STREET ADD 2400 ST F BRECKEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTII A. BUILDIN 00818 PROVIDER OR SUPPLIER VCIS HOME STREET ADDRESS, CITY, S 2400 ST FRANCIS DR BRECKENRIDGE, MN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 2 900 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 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 <td>TOP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING </td> <td>TO P DEFICIENCIES OF CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING B. WING (x2) MULTIPLE CONSTRUCTION B. WING</td>	TOP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	TO P DEFICIENCIES OF CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING B. WING (x2) MULTIPLE CONSTRUCTION B. WING

Minneso	ota Department of He	ealth				FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
	PROVIDER OR SUPPLIER	00010	STREET ADD	DRESS CITY S	STATE, ZIP CODE	02/1	0/2012
STERA	ICIS HOME		BRECKEN	IRIDGE, MN	56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	age 8		2 900			
	was new and she a added the Duodern on the coccyx as be under it. R88 was t	d shallow. NA-H state opplies cream after can n dressing does not v owel movement (BM) ransferred to her whe ushion was observed	ares. She work well) gets eelchair				
	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.						
	(LPN)-C was quest the PU and she sta Duoderm was on o it. She added the n tell her if it has falle The electronic med (MAR) was reviewed	a.m. licensed practic ioned about the treat ited she was not sure r not as she had not ursing assistants will en off. lication administration ed with LPN-C and d ent to check the Duoc	ment for if checked usually n record id not				
	repositioning scheo gotten to R88 yet a resident first. NA-H	I was questioned abo dule. She stated she nd she had to help a added that the nurse nd put Duoderm on.	has not nother				
Minnesota	to wheel R88 to he room. R88 was tran Following perineal and applied thin Du NA-H verified at tha assisted with repos	rsing assistant was of er room. LPN-C was a nsferred into bed via care, LPN-C cleanse uoderm to the area. at time R88 had not b sitioning since she wa 7:30 a.m. (3 hours lat	also in the hoyer lift. d the PU been as gotten				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 00818		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
	ROVIDER OR SUPPLIER	00818	2400 ST F	 DRESS, CITY, S RANCIS DR IRIDGE, MN		02/1	6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	she should be repo At 10:40 a.m. the U interviewed. She ve followed and R88 s every 2 hours. RN-	sitioned every 2 hour Init Manager (RN-A) erified the plan of car hould have been rep A checked the electro ot contain a treatmer	was e was not ositioned onic MAR	2 900			
2 910	The Director of Nur policies and proced residents at risk or staff on pressure uf monitoring system TIME PERIOD FOR (21) days MN Rule 4658.052	THOD OF CORRECT sing or designee cou- lures regarding care with pressure ulcers, cers protocols and d to ensure compliance R CORRECTION: Th 5 Subp. 5 A.B Rehab	Ild review for educate evelop a e. wenty one	2 910			
	have a continuous management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home program of bowel and duce incontinence an f catheters. Based o ident assessment, a that: tho enters a nursing h g catheter is not cath s clinical condition in was necessary; and no is incontinent of blue treatment and serve t infections and to re- ler function as possil	d bladder d the n the nursing nome neterized dicates l adder rices to estore as				

Minnesc	ta Department of He	ealth				FORM	APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	ETED
		00818				02/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST FRAN	ICIS HOME			RANCIS DF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ige 10		2 910			
	by: Based on observative review, the facility free facilit	ent is not met as evi ion, interview and do ailed to provide timel ontinence care for 1 nple with incontinence on 2/15/12 and 2/16/1 Data Set (MDS) com R88 required extens h all activities of daily	cument y of 2 (R88) e. with l2. pleted on sive to				
	(ADLs), was freque had severe cognitiv The quarterly MDS indicated R88 was due to progression plan of care dated required assistance disease and to che 2 hours and as nee	ently incontinent of un re impairment. completed on 12/30, always incontinent or of Alzheimer's diseas 1/21/09, indicated R8 with ADLs due to Al ck pad for incontinent eded.	rine, and (11, - urine se. The 88 zheimer's ce every				
	10/8/11, updated 1	dder Assessment da 2/29/11, indicated Rence and was on a ch very 2 hours.	88 had				
Minnesota D	lying on her right signed remain positioned of 10:00 a.m. when N into her room to pro NA-H stated the lass incontinence was a	a.m. R88 was observed de. R88 was observed on her right side in be ursing Assistant (NA) ovide morning cares. st time R88 was cheo t approximately 7:30 y R88 gets up earlier	ed to ed until)-H went The eked for) a.m				

Minneso	ta Department of He	ealth				FORM	APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	ETED
		00818				02/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ST FRAM	ICIS HOME			RANCIS DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ige 11		2 910			
	"other priorities pre	vented that today." P and R88 had been in					
	the w/c in the dining breakfast at 8:15 a.	a.m. R88 was obser g room. She was ser .m At 9:20 a.m. she ig area at the end of	ved was				
	At 10:20 a.m. NA-H was questioned about R88 toileting schedule. She stated she has not gotte to R88 yet and she had to help another residen first.		ot gotten				
	to wheel R88 to he into bed via hoyer li with urine which ha NA-H verified at tha assisted with toiletin	rsing assistant was o er room. R88 was trai ift. R88's brief was sa d leaked through her at time R88 had not b ng since she was got m. (3 hours later) and every 2 hours.	nsferred aturated pants. been tten out of				
	interviewed. She ve	Init Manager (RN-A) erified the plan of car hould have been che 2 hours.	e was not				
Minnesota D	director of nursing of policies and proced receive appropriate director of nursing of	THOD OF CORRECT or designee could de lures to ensure reside incontinence cares. or designee could ed embers and develop s to ensure ongoing	velop ents The ucate all				

Minneso	ta Department of He	alth				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		00818		D. WING _		02/1	6/2012
NAME OF P	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
ST FRAM	ICIS HOME			RANCIS DR RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 12		2 910			
	TIME PERIOD FOR (21) Days	R CORRECTION: TV	venty one				
21015	MN Rule 4658.0610 Requirements- Sai	0 Subp. 7 Dietary Sta nitary conditi	aff	21015			
	procedures and cor	conditions. Sanitary nditions must be mai dietary department	ntained in				
	by: Based on observati review, the facility f foods in a sanitary hand hygiene prior the distribution of fo (Lady Slipper, Wild	ent is not met as evi ion, interview, and do ailed to ensure staff manner related to ap to touching food iten ood in 3 of 3 dining ro Flower, Railways). tential to affect all 11 n the facility.	ocument served propriate ns during poms This				
	Findings include:						
	Lady Slipper/Wild F	lower					
	was observed to had dining room, Lady S	3/12, the Prairie Mea ave two dining rooms Slipper had 15 reside ining room, Wild Flor g for their meal.	. The first ents sitting				
	dishing plates for th dining room. As sh reached directly inte gloved hand and pi	B donned gloves and ne residents in the La ne dished the meals, o the steam table wit cked up baked potat o reached into the co	idy Slipper she h her oes for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00818				02/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
ST FRAM	NCIS HOME			RANCIS DRI RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21015	Continued From pa	age 13		21015			
	dinner rolls and pic her gloves hand.	ked up a the dinner r	oll with				
	cards located in a f counter next to the returned to the stea gloves and again b the residents. She the dinner rolls and same gloved hands At 5:52 p.m. the die the meals for the 19 for the Lady Slipper dietary aide (DA)-C and the meal cart to Cook-B and DA-C	etary staff completed 5 residents and 3 roo r dining room. Cook then wheeled the st o the Wild Flower dir did not remove their	sting on a B then same meals for ectly touch with the dishing om trays B and eam table ing area. 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 rowith her gloved hand. At 6:00 p.m. all 14 residents in the Wild Flower dining room receiv their evening meal. The dietary staff did not change their gloves during the entire meal serv observed. 		oom. as she inner rolls 4 n received d not				
	observed in the Lac breakfast meal was	5/12, the breakfast n dy Slipper dining roor s an open breakfast i would prepare the m	n. The n which				
	preparing a meal for	g assistant (NA)-J be or a resident. She do bread into a toaster.	nned				

Minnesota Department of Health						APPROVED
	PROVIDER/SUPPLIER		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLE	ETED
	00818	070557 400			02/1	6/2012
NAME OF PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ST FRANCIS HOME		2400 ST FF BRECKEN				
(X4) ID SUMMARY STATEME PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21015Continued From page 14 touched the toaster with then went to the freezer bag of sausages, opene removed three sausages sausages on a plate, op closed the door, started replaced the bag back in opened a drawer, remove it with fruit. She placed is then went to a small stead boiled eggs from the compeel the egg. She place plate, removed the bread buttered it, and removed microwave. She arrang the resident's plate touch gloves, picked up the trading resident on the unit.At 8:44 a.m. NA-K donne hand and placed a slice She then donned a second the steam table and rem pealed the egg and plac opened a drawer, removied with mixed fruit. At 8:45 toast from the toaster, b plate and cut the egg with She then delivered the resident's hat then returned to the toaster. She she walked over to a rest kitchen counter. She tal touched the resident's hat then returned to the toaster butter and jelly to the toaster	a her gloved hand and removed a z ed the bag, and the s. She then place bened the microw the microwave a in the freezer. She ved a small bowl the fruit cup on a am table and rem intainer and proce ed the pealed egg ad from the toaste d the sausages fr ged each of the ite shing the food with the sausages fr ged a glove on he of bread into the bond glove, reache noved a boiled egg ad it on a plate. St wed a small bowl, bar. she removed a small bowl, bar. She remo	zip lock hen wed the vave, and he then and filled heray and noved a weded to g on a weded to g on a eeded to g on a eer, rom the ems on h her d her it to a r left toaster. ed into gged, She then filled it ed the lit on the ed hand. t in the p placing on as he ent, nter. She d the r adding	21015			

Minneso	ta Department of He	ealth					
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		00818			STATE, ZIP CODE	02/10	6/2012
	ROVIDER OR SUPPLIER		2400 ST F	RANCIS DR	live		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE (MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21015	observed to remove delivered the toast room. Railways During meal observe room at 5:00 p.m. of being served suppe gloves without was 2 pieces of bread fit them into the toaste toasting, DA-B ope took out a plate, sh drawer and took ou gloved hands DA-B toaster and procee brought it to a resid sanitize her hands of meal service. During observation approximately 5:13 wearing gloves. NA with buttering their to their baked potat butter on the floor, gloved hands and p continued to assist their rolls and potat contaminated gloves	age 15 the dining room. She her gloves after she to the resident in the on 2/13/12, 16 reside er. DA-B donned a p hing her hands first. I rom the bread bag ar er. While the bread w ned the upper cupbo e then opened the si it a knife. With the sa removed the bread ded to butter it and th lent. DA-B did not wa during any of the obs of the same meal at p.m. NA-I was obset to a sasisting the r dinner rolls and apply toes. NA-I dropped a picked it up with the solaced it on the table the residents with but toes. NA-I did not ren es or sanitize her han er pat from the floor.	e had dining dining at dining nts were air of DA-B took nd placed /as ard and lverware me from the nen ish or rerved residents ying butter pat of same and ittering nove her	21015			
Vinnesota D		?7 a.m. on the Railwa es, but was not obser					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 00818		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL 	
	PROVIDER OR SUPPLIER		2400 ST F	RESS, CITY, S RANCIS DR RIDGE, MN			0,2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21015	wash hands or use baked beans to res At 11:33 a.m. cook the steam table with the same gloved ha handle buns. Cook fries and buns with 19 residents on tha At 11:48 a.m. cook handle the buns or she used gloved ha utensils because it open and get the rig On 2/15/12, at 12:2 nutritional services have either used ha prior to serving resi verified after cook-/ steam cart, she sho hands or used hand gloves prior to serv stated the policy dir touch food the resid added if staff have surfaces, they need either wash or use to handle food. The facility policy tir 5/10, directed staff gloves, after remov with objects and eq immediate vicinity.	hand sanitizer prior idents. A touched a piece o h her gloved hand, th and to scoop steak fr A continued to hand the same gloved hand	f paper on hen used les and dle steak hd until all e tongs to e stated or e buns e fries. f food and should hed hands NS on the hed her DFNS gloves to The DFNS other dirty oves, and oly a glove eviewed e donning contact ent's	21015			

Minneso	ota Department of He	ealth				FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION G	(X3) DATE S COMPL	ETED
		00818			STATE, ZIP CODE	02/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER						
ST FRAI	NCIS HOME			RANCIS DR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
21015	Continued From pa	age 17		21015			
	to assure that food manner. Staff coul The Certified Dieta service of food on a	rvice policies and pro is served in a sanita ld be trained as nece ry Manager could mo a periodic basis. R CORRECTION: T	ry ssary. onitor the				
21375	Program Subpart 1. Infection home must establis	0 Subp. 1 Infection C on control program. sh and maintain an ir signed to provide a sent.	A nursing	21375			
	by: Based on observat review, the facility f washing while prov	ent is not met as evi ion, interview and do failed to ensure prope riding care for 1 of 4 (mple observed to rec	cument er hand (R88)				
Minnesota D	prior to providing p On 2/16/12, at 10: was observed to w Licensed practical room. R88 was trai R88's brief was sat applied gloves and removing the brief	ge gloves and/or was ressure ulcer cares f 30 a.m. a nursing as heel R88 to her roor nurse (LPN)-C was a nsferred into bed via turated with urine. LP proceeded to assist and providing perines the pressure ulcer. V	or R88. sistant n. Ilso in the hoyer lift. 'N-C with al care.				

Minneso	ota Department of He	ealth				FORM	APPROVEL
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	ETED
		00818				02/1	6/2012
NAME OF F	AME OF PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ST FRAI	NCIS HOME			RANCIS DR RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	removing her glove pick up the Duoder pressure ulcers) pa and then used the s dry the coccyx area over the pressure u gloves. With the sa grabbed a roll of ga resident's drawer a assistant. She then without washing he clothing, bedding a point LPN-C used disinfect her hands verified after the of have changed glov Duoderm. The Handwashing the following: Hand after touching blood excretions, and cor not gloves are worr are removed; and v avoid transfer of m residents, personne Some examples, b touching wounds of any item or surface contaminated. Suggested Method administrator or de procedures regardi could educate staff	age 18 es, LPN-C then proce m (dressing for treat ackage (had pre-cut p soaker pad under R8 a. LPN-C applied the llcer with the contam me gloved hands LF arbage bags from the nd passed them to the removed her gloves is hands proceeded to nd the hoyer sling. A alcohol based foam prior to leaving the r bservation that she s es prior to applying the hygiene must be pe d, body fluids, secret ntaminated items, when n, and immediately ai when otherwise indici- icroorganisms to othe el and/or the environ- ut not limited to: be f any kind, after to that may have been of Correction: The signee could review ng infection control. on policy and procea- ng system to ensure	ment of pieces) 88 to pat e Duoderm inated PN-C ene nursing and o adjust t that to room. She hould he dicated rformed ions, nether or fter gloves ated to er ment. efore uching policy and Facility	21375			

Minnesc	ta Department of He	ealth I				I	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING		(X3) DATE S COMPL	
		00818		B. WING		02/1	6/2012
NAME OF F	ROVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
ST FRAN	ICIS HOME			RANCIS DRI IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ige 19		21375			
	Time Period for Co days.	rrection: Twenty one	e (21)				
21475	MN Rule 4658.100 General Requireme	5 Subp. 1 Social Ser ents	vices:	21475			
	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 reside who is in need of additional mental health, substance abuse, or financial services.		rvices cally A resident				
	by: Based on observati review, the facility f and appropriate so	ent is not met as evi ion, interview, and do ailed to assure that s cial services interven of 1 resident (R32) g behaviors.	ocument sufficient itions				
	Findings include:						
	dementia. The qua (MDS) dated 11/28 cognitive impairme assistance with all a MDS also revealed concentrating, beca	ame easily annoyed ved wandering behavi	i Set ith extensive g. The with				
	assessment of the including: when the	lacked a comprehen wandering behaviors behaviors occurred crease the behaviors	5				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 00818		A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL 	
AME OF I	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
ST FRA	NCIS HOME			RANCIS DRI RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21475	evaluation of the be The current plan of identified R32 as ha exhibiting behaviors combativeness with interventions identifi behaviors that inclu- medication). Howe non-pharmacologic implemented when Review of the Mood from 12/18/11 - 2/1 separate incidents of The behavior notes wandered in the ev- redirect. A note da been wandering int had been difficult to indicated R32 had n another resident's r Review of the social documentation rela past year was lacki At 4:40 p.m. on 2/1 occasionally wande permission. She st and it bothered her her room. She also loud during meals a 2/13/12, she had to because of R32's b upset. At 6:00 p.m. on 2/1	chaviors. care printed on 2/16 aving delusional thin s such as wandering n cares. The care pla fied R32's medicatio ided Seroquel (antip- ever, the care plan la cal interventions to be R32 displayed the b d and Behavior docu 5/12, revealed R32 f of wandering behavi a dated 1/2/12, indicate o other resident roor o redirect. A note dat required assistance f room. al service notes ident ted to R32's behavior	king and and an ins for sychotic cked e ehaviors. mentation had 14 ors. ited R32 cult to d R32 had ns and ed 2/7/12, to leave ified ors in the R32 would but e items me into d become meal on im ng her	21475			

Minnesc	ota Department of He	ealth					APPROVEI
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
		00818	T			02/1	6/2012
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
ST FRANCIS HOME				RANCIS DRI IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21475	Continued From pa	age 21		21475			
	incident.						
	wheelchair wander Neighborhood. Sh independently whe	el herself down the h tit door. She was not	adows allway				
	wander into his roo permission. He sta	4/12, R95 reported F om and take items wit ated the staff membe ndered into other res	thout his rs were				
	(FM-1) stated R32 into 105's room wh	(14/12, R105's family would occasionally w ich was upsetting to lity staff members we ehaviors.	/ander R105.				
	stated R32 would v rooms and would ta the rooms. She sta in another resident out of the room. Si to redirect at time. other residents on R32's behavior and concerns related to time, she reviewed record did not conta	5/12, registered nurs vander into other rest ake the personal item ated when the staff n room, they are to as he stated R32 was ve She stated R32 was ve She stated she was of the unit were bothered was not aware of ar o R32's behaviors. A R32's record and ve ain a comprehensive wandering behaviors	ident ns from otice R32 sist her ery difficult unaware ed by ny family t that rified the				
	stated she was awa other resident room	5/12, quality of life ai are R32 would wand ns, but stated she wa ⁄ior bothering any of t	er into Is not				

Minneso	ta Department of He	ealth				FORM	APPROVED
STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLI	
L		00818		B. WING _		02/1	6/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
ST FRAN	ICIS HOME			RANCIS DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21475	to engage the resid was wandering, but At 2:03 p.m. on 2/1 stated he had beer on 2/13/12. He stat being very loud in t became upset and behaviors and left f R46 ate her meal in behaviors. At 2:30 p.m. on 2/1 (LSW)-A stated show wandering behavior which she wandered She stated some of concerns related to behaviors, but she concerns to determ displaying the behavior interventions were behaviors. She ver comprehensive bel behaviors. Suggested Method administrator or de the policy and proc behaviors. The fac staff on policy and develop a monitorin compliance.	age 22 ted she would at time dent in an activity whe t it didn't always work 5/12, nursing assistan working during the r ted R32 had an episo he dining room and F nervous because of the dining room. He n her room because of 6/12, licensed social e was aware of R32's rs, including behavio ed into other resident ther resident's wander had not investigated nine which resident w avior to ensure appro- in place to decrease erified she had not co havior assessment of f Correction: The signee could review a edures as related to cility could educate ap procedures. The fac ng system to ensure	en she nt (NA)-O noon meal ode of R46 her stated of R32's worker s rs in rooms. ade ing the as priate the mpleted a f R32's and revise wandering propriate ility could	21475			
21665	-	0 Physical Environme	ent	21665			
Minnesota De STATE FORI	epartment of Health M		6	⁶⁸⁹⁹ C	COTG11	If continuation	on sheet 23 of 29

Minneso	ta Department of He	alth						
		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	PLE CONSTRUCTION G	. COMPLE	(X3) DATE SURVEY COMPLETED 02/16/2012	
	ROVIDER OR SUPPLIER	00010		DRESS CITY S	STATE, ZIP CODE	02/1	0/2012	
2400 ST FRANCIS LIGHT			RANCIS DE	RIVE				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	/E ACTION SHOULD BECOMPLETED TO THE APPROPRIATEDATE		
21665	Continued From par A nursing home m functional, comforta environment, allowi personal belonging This MN Requireme by: Based on observati failed to maintain a accident hazards in neighborhoods (Ra in which electric fire practice had the po independently mob Findings include: Railways unit Northern Pacific Lir Wild Rice River/Re On 2/13/12, at 7:13 within the lounge be and Milwaukee Roa unit did not appear present. However, ventilation grill the f touch. No residents that time.		ean, hysical e ble. denced f facility f potential 2 of 3 eadows) This he e units. ine and ireplaces cated ific Line ilways was k to the lounge at	21665			DATE	
Ainnesota D	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.							

Minneso	ta Department of He	ealth					
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 00818			A. BUILDING		(X3) DATE S COMPL		
			B. WING		02/1	6/2012	
IAME OF PROVIDER OR SUPPLIER STREET A			STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
			RANCIS DRI RIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	age 24		21665			
	touch along the upp residents in wheeld at that time, the clo approximately 8 fee the residents attem wheelchairs. At 11:30 a.m. no re	et from the fireplace. Inpted to propel their esidents were in the I	grill. Four inge area None of ounge at				
	this time. The fireplace ventilation grill remaine very hot at this time. On 2/14/12, at 2:24 p.m. nursing assistant (NA						
	Stated she had new When shown that t yet was hot to touc NA-A stated she had NA-A stated she gu turn on the fireplace thermometers used the temperature. Never touched the fin sustained a burn the	es on. ook on, on grill, t before. would re of any monitor ents had					
	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.						
	never seen the fire	I p.m. NA-C stated s place on. NA-C stat sidents feel the firepl urned.	ed she				
	On 2/14/12, at 2:34	I n m the director of	nlant				

Minneso	ota Department of He	ealth					APPROVEL
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00818			A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPLI	ETED
						02/1	6/2012
NAME OF I	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
ST FRAI	NCIS HOME			RANCIS DRI RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21665	operations (DPO) of lounge between W the North. At that t are terribly hot." The disconnected right up signs that said: On 2/15/12, at app 2/16/12, at 8:30 a.r unit between the Ne Milwaukee Road Li hot. On 2/16/12, at 9:05 verified there were affected. Soo Line/Great Not On 2/13/12, at 7:20 between the Soo L Line hall located or was observed to be approximately 3 fee foot deep. It had a the front of it. The f with a 2 inch black touched the black r extremely hot to the greater than 1 seco approximately 15 fe another resident wa reclining chair. At 8:30 a.m. on 2/1 observed to be on, area as they were e	checked the fireplace ild Rice River and R ime, the DPO stated in DPO stated they now and added they	ed River of d, "They vould be v would put and on he Railway and the not feel (UC)-A se areas (UC)-A se areas (21665			

ND PLAN OF CORRECTION		1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/16/2012		
NAME OF F				RESS, CITY, S	TATE, ZIP CODE	· · · ·	0/2012
ST FRAI	NCIS HOME			RANCIS DRI RIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21665	to the touch. One r wheelchair approxim fireplace. At 10:33 a extremely hot to the seated approximate however, none of th be wandering near At 2:24 p.m. on 2/1 stated they had new were not sure how had not seen any re fireplace. At this sa noticed the fireplac 2/12/12, and had th working again. The director of plan interviewed at 2:11 the staff turned the thought they were r added, "I don't reall they are supposed are turned off every there was not a wa surface temperatur maintenance depar a standard prevents the monitoring of th thought the nursing On 2/14/12, at 2:38 Quality and Clinical confirmed the nursi policy on the use an neighborhood firepl At 2:24 p.m. on 2/1	resident was sitting in mately 5 feet from th a.m. the fireplace rer touch. Six resident ely 4 feet from the fir- ne residents were ob the fireplace. 4/12, NA-E, NA-H, a ver turned on the fire it worked. They add esidents get close to me time, NA-G state e running on Sunday hought it had been fix to operations (DPO) p.m. on 2/14/12, and fireplaces on and of remote controlled. T ly know much about to check and make s v evening." The DPO y to monitor the firep es. The DPO stated the the the the the the the ative maintenance p the fireplaces, but ado department may ha s p.m. registered nurs Financial Coordinat ing department did n nd monitoring of the laces. 4/12, the DPO tested nd B fireplaces. The	e mained is were eplace, served to nd NA-F place and ed they the ed she had morning ted and was d stated, f, and he he DPO those, sure they D added laces the a policy or rogram for led he ve one. se (RN) or ot have a	21665			

Minnesc	ta Department of He	ealth					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		00818				02/1	6/2012
ST EDANCIS HOME			2400 ST F	RANCIS DE RANCIS DE RIDGE, MN			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21665	Fahrenheit, and the measured 168 deg verified that these r and immediately tu pulling out the switc heat source. The I not know they were Prairie Meadows un	e mantel on Railways rees Fahrenheit. The measurements were rned both fireplaces ches that connected DPO further added, " e that hot."	DPO not safe off by to the We did	21665			
	fireplaces were obs On 2/14/12, at 3:24 they could not reca on the Prairie Mead on and were unsure places. On 2/13/12, at 2:27 fireplaces had beer season but was una On 2/14/12, at 2:30 fireplaces on the Pr were not used. She equipped with a cor enclosure on the bo turned the fireplaces On 2/15/12, at 9:05 director stated he h from the fireplaces	p.m. NA-L and NA-I II the last time the fire dow neighborhood ha e how to turn on the f r p.m. NA-N stated th n on during the Chris sure how to turn it on p.m. RN-B stated th rairie Meadow Neighl e stated the fireplace ntrol panel behind the ottom of the fireplace	M stated eplaces ad been fire tmas le. borhood es were e metal which ce n knobs able.				
Minnesota D	epartment of Health						
STATE FOR	-			⁶⁸⁹⁹ C	COTG11	If continuatio	n sheet 28 of 29

winnes	ota Department of He	alth					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION N 00818			A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED - 02/16/2012	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		0,2012
ST FRAI	NCIS HOME		2400 ST F	RANCIS DR IRIDGE, MN	RIVE		
(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 CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21665	The director of mai could develop and procedures to ensu fireplaces are main Ongoing maintenar keeping could ensu for the residents, st could develop a sys an ongoing basis to	Ige 28 Intenance or his designinglement policies and tree that the nursing here that the nursing and runce, monitoring and runce that the fire places aff and visitors. The stem to audit the fire places aff and visitors. The stem to audit the fire of ensure compliance.	nd ome ner. ecord s are safe facility places on	21665			