#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GUFD PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00818 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) ST FRANCIS HOME (L1) 1. Initial 2. Recertification (L4) 2400 ST FRANCIS DRIVE 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination 003543200 (L6) 56520 (L2)(L5) BRECKENRIDGE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (L9) 01 Hospital 05 HHA 13 PTIP 09 ESRD 22 CLIA 07/22/2016 6. DATE OF SURVEY (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 08 OPT/SP 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: \_\_\_\_ 2. Technical Personnel To (b): Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 80 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 80 (L17) 13. Total Certified Beds **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)\* Code: 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 80 (L37) (1.38)(L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Teresa Ament, Unit Supervisor 07/29/2016 Mark Weeth, Enforcement Specialist 09/09/2016 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: 2 Facility is not Eligible

2. Facility is not Eligio	(L21)			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY <u>00</u>	INVOLUNTARY
06/01/1984			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS	S	03-Risk of Involuntary Termination	<u>OTHER</u>
	A. Suspension of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Suspension Date:	(L44)		00-Active
	B. Resellid Suspension Date.	(L45)		
28. TERMINATION DATE:	29. INTERMEDIA	ARY/CARRIER NO.	30. REMARKS	
	03001			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINAT	TION OF APPROVAL DATE		
	<b>07/22/2016</b> (L32)	(L33)	DETERMINATION APPROVAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245265

September 9, 2016

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

Dear Mr. Nelson:

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

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

Effective July 18, 2016 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 29, 2016

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

RE: Project Number \$5265025

Dear Mr. Nelson:

On June 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective July 18, 2016 and therefore remedies outlined in our letter to you dated June 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this Notice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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

### POST-CERTIFICATION REVISIT REPORT

			PU31	CERI	IFIC	AHONI	KEVISII KE	PURI			
	R / SUPPLIER / C	LIA /	MULTIPLE CONS	TRUCTION						DATE O	F REVISIT
IDENTIFIC 245265	CATION NUMBER	Y1	A. Building B. Wing						Y2	7/22/20	16 <sub>Y3</sub>
NAME OF	FACILITY					ST	REET ADDRESS, CIT	Y, STATE, ZIF	CODE		
ST FRAN	ICIS HOME					24	00 ST FRANCIS DRIVI	E			
						BF	RECKENRIDGE, MN 56	6520			
program, corrected provision	to show those dand the date su	eficiencie ich correc	s previously repo tive action was a	rted on the complished	CMS-25 d. Each	667, Statemen deficiency sho	for Clinical Laborator t of Deficiencies and buld be fully identifie 7 (prefix codes show	Plan of Cor d using eithe	rection, that have er the regulation or	r LSC	
ITEI	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0241		Correction	ID Prefix	F0282		Correction	ID Prefix	F0309		Correction
Reg.#	483.15(a)		Completed	Reg.#	483.20(	k)(3)(ii)	Completed	Reg. #	483.25		Completed
LSC			07/18/2016	LSC			07/18/2016	LSC			07/18/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			-	LSC				LSC			Completed
			_								
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
LSC			_	LSC				LSC			
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Reg.#			Completed	Reg. #			Completed	Reg. #			Completed
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ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC			-	LSC				LSC			
REVIEWE STATE AG		REVIEW (INITIAL	ED BY s) TA/mm	DATE 07/29/2	016	SIGNATURE C	of surveyor 2943	3		DATE 07/22	2/2016
REVIEWE CMS RO	D BY	REVIEW (INITIAL:		DATE		TITLE				DATE	

6/9/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

## **POST-CERTIFICATION REVISIT REPORT**

	R / SUPPLIE CATION NUM		LIA /	MULTIPLE CONS A. Building 02 - B. Wing	TRUCTION MAIN BUIL	.DING					Y2	DATE O 7/18/20	F REVISIT
NAME OF ST FRAN	FACILITY ICIS HOME	<u> </u>						2400 ST	ADDRESS, CIT FRANCIS DRIV ENRIDGE, MN 56	E	CODE		
program, corrected provision	to show the	ose d ite su d the	eficiencie ich correc	s previously repo tive action was a	rted on the ccomplished	CMS-25 d. Each	567, Staten deficiency	nent of Description	eficiencies and e fully identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation o of each requireme	r LSC	
ITE	VI			DATE	ITEM				DATE	ITEM			DATE
Y4				Y5	Y4				Y5	Y4			Y5
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #	NFPA 101			Completed	Reg. #	NFPA 1	01		Completed	Reg. #	NFPA 101		Completed
LSC	K0022			06/23/2016 	LSC	K0038			06/20/2016	LSC	K0062		06/23/2016
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#	NFPA 101			Completed	Reg.#				Completed	Reg. #			Completed
LSC	K0144			- 06/23/2016 -	LSC					LSC			
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg. #				Completed	Reg. #				Completed	Reg. #			Completed
LSC					LSC					LSC			
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#				Completed	Reg. #				Completed	Reg. #			Completed
LSC				_	LSC					LSC			
ID Prefix				Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#				Completed	Reg. #				Completed	Reg. #			Completed
LSC				_	LSC					LSC			
REVIEWE STATE AG		×	REVIEW (INITIAL		DATE 07/29/2	2016	SIGNATUR	RE OF SUI	RVEYOR 3653	36		DATE 07/18	3/2016
REVIEWE CMS RO	D BY		REVIEW (INITIAL		DATE		TITLE					DATE	
<b>FOLLOW</b> ( 6/8/2016	JP TO SURV	EY C	OMPLETE	D ON					DEFICIENCIES CMS-2567) SEN			YES	S NO

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GUFD

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	T I - TO BE COM	IPLETED BY T	HE STAT	E SURVEY AC	GENCY	I	Facility ID: 00818
MEDICARE/MEDICAID PRO     (L1)		3. NAME AND AD (L3) ST FRANCI (L4) 2400 ST FRA (L5) BRECKENF	ANCIS DRIVE	ΓY	(L6)	56520	4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation  7. On-Site Visit	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGORY	7 09 ESRD	02 (L7	7) 22 CLIA	8. Full Survey After Co	
	06/09/2016 (L34)(L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICA From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	80 (L18) 80 (L17)	A. In Complia  Program Re Compliance1. /	equirements		2. Tec 3. 241 4. 7-D	hnical Personnel	Following Requirements:  6. Scope of Serv 7. Medical Direc 8. Patient Room : 9. Beds/Room  (L12)	etor
14. LTC CERTIFIED BED BREA 18 SNF 18/	KDOWN 19 SNF 19 SNF 80	ICF	IID		15. FACILITY 1		(L15)	
(L37) (  16. STATE SURVEY AGENCY I  17. SURVEYOR SIGNATURE  Tammy Williams.		(L42)  SHOW LTC CANCELI  Date :	(L43) LATION DATE): 07/13/2016		Mark T	RVEY AGENCY API Meath nent Specialis		Date:
Tarriiriy vviillairis				(L19)	-			07/22/2016 (L20)
19. DETERMINATION OF ELIC  _X	SIBILITY ble to Participate		D BY HCFA REMAILIANCE WITH CHIS ACT:		21. 1. 2.	Statement of Financia	E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF/	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  06/01/1984  (L24)	23. LTC AGREEI BEGINNING (L41)	G DATE	24. LTC AGREEME ENDING DATE (L25)		VOLUNTARY 01-Merger, Clos 02-Dissatisfaction		INVOLUNT 05-Fail to M	L30) FARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE:	27)	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason		OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	29. INTERMEDIARY/C 03001	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	32. DETERMINATION	OF APPROVAL DAT	(L33)	DETERMIN	ATION APPRO	VAL	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 24, 2016

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

RE: Project Number S5265025

Dear Mr. Nelson:

On June 9, 2016, 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

### DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us

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

### **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 19, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

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

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 9, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

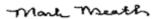
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

## Sincerely,



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

Fax: (651) 215-9697

PRINTED: 07/13/2016 FORM APPROVED OMB NO. 0938-0391

			(X3) DATE SURVEY COMPLETED		
		245265	B. WING _		06/09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	rs	F 00	00	
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required if first page of the CMS-2567 ic submission of the POC will cion of compliance.			
F 241 SS=D	on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with	F 24	41	7/18/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in its or her individuality.			
	by: Based on observate review the facility far dignified manner foutilized a transfer by Finding include: R10's annual Minim 3/4/16, identified Rincluded: diabetes, The MDS identified impairment and recone staff for bed me	num Data Set (MDS) dated 10 had diagnoses which Parkinson's, and dementia. R10 had moderate cognitive juired extensive assistance of obility and transfers. The MDS		Facility assessed the identified res that was wearing a gait belt at all tir when up for necessity. The care ple changed to reflect that gait belt is not needed at all times prior the survey leaving our facility.  Facility will assess all residents that a gait belt at all times when up for necessity and ensure that dignity is respected. Care plan documentation be in place for the necessity and the resident's safety and dignity is responding the instance where a reside	mes an was ot ors  t wear being on will at the ected. nt
_ABORATOR\	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

**Electronically Signed** 

06/30/2016

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245265	B. WING			06/0	09/2016
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 400 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	one staff to walk in to walk in corridor at R10's current care R10 had a self cardliving (ADL's) related lack of follow through indicated R10 use of a front whee frequent cueing or her walker, which reare plan also indicated requent cueing or her walker, which reare plan also indicated reare plan also i	needed limited assistance of her room, supervision of staff and on and off the unit.  plan dated 11/5/11, indicated e deficit of activities of daily ed to weakness, confusion, gh and Parkinson's. The care walked independently with the eled walker (FWW), needed would become lost, forgetting equired staff to retrieve. The cated R10 would self transfer tance with transfers to get in and utilized a transfer belt to when up.  p.m. R10 was seated in the	F 2	241	would wear a gait belt at all times, the resident's dignity will be respected. The resident using a gait belt at all times be assessed on a daily basis to detend whether or not they feel comfortable wearing the belt. Education will be provided to staff on gait belts related dignity concerns.  We currently have no residents were gait belts at all times. In the event a resident would wear a gait belt at all times, a daily assessment log will be placed on the eMAR every AM and licensed staff to ask resident if they comfortable with wearing the gait be all times. Audits will be conducted for dignity and reviewed at the QA& committee meetings.  Overall responsibility is the DON.	Any s will ermine e d to aring a I e PM for are elt at weekly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245265	B. WING _		06	/09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	reading a magazine fastened around her fastened around her on 6/8/16, at 7:33 a personal cares, N/A around R10's waist independently, dow At 8:01 a.m. R10 w independently back. The transfer belt remains breast/rib cage areatransfer belt remains room. R10 w LPN-C to sit down in At 8:30 a.m. R10 cape dining room table, in the dining room. In the dining room, in her recliner and obelt fastened up un At 11:30 a.m. R10 windependently with belt fastened under 1:00 p.m. R10 was at a magazine with under her breast/rib remained in her recliner and to wear the she did not fall. R10 around my belly will said "I don't like it." up and then I have	d next to her table in her room e with the transfer belt er waist.  a.m. during observation of A-D placed a transfer belt. R10 then walked en the hallway using her FWW. as observed ambulating a to her room using her FWW. as fastened up under her a. At 8:15 a.m. with the hing fastened under R10's a, Licensed practical nurse at 10 to stand from her recliner. Indently with her FWW to the was given verbal cues from	F 24	11		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245265	B. WING			06/0	09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 241	all the time. Staff hat tell her she wouldn'r rather not have it or to walk independent ambulation.  On 6/9/16, at 1:35 pconfirmed R10 word all day, she was indusing her FWW and the place." NA-E industry assistance to get in felt R10 was not a fat ransfer belt on be plan, but didn't know time. NA-E felt it was wear her transfer be would not want to would not want to would not want to wood on 6/9/16 at 1:39 pconfirmed R10 word all day and confirmed plan. RN-A indicate get in and out of chitning in the morning transfer herself at time wore the transfer be easier for us to get chairs." RN-A felt R was up for the day, ambulation using he was not aware that belt. RN-A indicted transfer belt around for her to have it on On 6/9/16, at 2:22 pc.	transfer belt around her waist as not removed the belt, then to an temoved the belt, then to want to fall. R10 stated "I'd n." R10 indicated she was able the transfer belt consistently rependent with ambulation distated "she will walk all over dicated R10 needed staff and out of the chair and she all risk. NA-E stated R10 had recause it was on the care with why R10 had it on all the rear one all the time. Was not dignified to have R10 rear one all the time."  Im. registered nurse (RN)-A rear one all the time."  Im. registered nurse (RN)-A rear one all the time."  Im. registered nurse (RN)-A rear one all the time."  Im. registered nurse (RN)-A rear one all the time. The rear one all the time. The rear one all the time. The rear one all the time and that was why she rear one all the time. RN-A stated "its her up and down from the rear one all the time. RN-A stated "its her up and down from the rear one all risk once she she was independent with the rear of the rear one all the time. RN-A indicted she R10 did not want to wear the rear one if R10 did not want the rear one if R10 did not want the rear one all the rear one all risk once she she was independent with the rear one all the rear one all risk once she she was independent with the rear one all the rear one all risk once she she was independent with the rear one all the rear one all risk once she she was independent with the rear one all the time.	F 2	41			

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245265	B. WING		06/0	9/2016
NAME OF PROV	VIDER OR SUPPLIER  6 HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
coi the Th wo ind the dig R1 that Re Pa Re fac you and rec SS=D Th mu acc car Th by:  Barevinte (Rime Fire R4	e transfer belt to he DON also state be DON also state build never do it."  dependent with an e unit. The DON a gnified to have the lo's breast/rib cage at would be uncoreview of the undaratients/Clients/Reserview of the undaratients/Clients/Reserview in a manner and enhances your cognition of your is 3.20(k)(3)(ii) SEFERSONS/PER CARESONS/PER CARESONS/PE	The DON stated "we do use nelp her up with transfers." ed "if it bothered a resident, I The DON confirmed R10 was industrial must be transfer belt riding up under ge area and stated "potentially infortable for the resident."  ted, facility policy titled sidents Rights and dicated under Dignity: "the urtesy promote and care for d environment that maintains dignity and respect in full individuality".  RVICES BY QUALIFIED	F 241		ect R41. in & tate: o be chart. ent on	7/18/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245265	B. WING		06/09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLÉTION
F 282	congestive heart fairregular pulse, Alzl moderate cognitive an anticoagulant m  R41's care plan da Category: Anticoag Coumadin for atrial for s/s (signs and sidentified s/s of bled)  On 6/6/16, at 7:30 phave a dark purple back of the right had diagonally from R4 above the wrist. The during observations 6/8/16, at 11:33 p.n.  Review of R41's prothrough 6/9/16, did bruising during this term care plan with 5/16/16, did not incobruising. The facilit Healed Skin and Withrough 6/9/16, did documentation of both companies of the compan	illure, atrial fibrillation (a-fib), neimer disease/ dementia, with impairment and daily use of edication.  ded active 2/4/15, included, ulant Therapy Alert. Problem: fibrillation. Approach: Monitor ymptoms) of bleeding. The eding included bruising.  o.m. R41 was observed to to black oblong bruise on the end. The bruise extended end: The bruise extended end: The bruise remained the same on 6/7/16, at 2:00 p.m.; and: and 6/9/16, at 10:42, a.m ogress notes dated 3/1/16, not identify R41 had any time. Review of the short entries dated 9/1/15, through lude any documentation of y printed computer form titled yound Log dated 7/1/15, not include any	F 282	investigated, measured, and docu under skin & wound for further monitoring/follow up. An audit will done on care plans of residents the potential indications from check of that could be vulnerable to skin issed Updated check off sheets, which we easily assessable in the nurse's steed quick reference and charting clarified for when a bruise is found on a restrict tensed staff were educated on the meeting regarding expectations. All licensed staff were emailed the mister from the June meeting so those neattendance know expectations. Updated check off sheets placed in nurse's station on each unit for quereference and charting clarification when a bruise is found on a reside Bruising audits will be implemented DON and completed by licensed should a tresidents monthly, along with random audits and then they will be brought to the Quality Assurance Committee for further recommence Audits will ensure that bruises are documented correctly per policy. be educated when audits show incomplete documentation, and fir will be reported to Quality Assurance Committee.  Overall responsibility is the DON	be at have if sheet sues. will be ation for ication sident. 6-15-16 and ick in for ent. d by the taff. kly X 4, the e lation.  Staff will indings

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		245265	B. WING _		06	/09/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	On 6/9/16, at 1:34 p (LPN)-A verified R4 on the back of the r daily and did not hat this bruise.  On 6/9/16, at 1:41 p verified staff was exinterventions for residuct and the residual of Final Programments of Programments	ge 6  c.m. licensed practical nurse of did have a large dark bruise right hand, received Coumadin rive documentation regarding  c.m. registered nurse (RN)-B repected to follow the care plan sident care. RN-B verified no reflect that is bruising was found.  c.m. LPN-A identified R41 had draw on the prior Wednesday back of the right hand. LPN-A con the back of R41's hand m these procedures; however notation of the bruise was  c.m. RN-B indicated the bruise ld have been from the lab "We do not do any skin and or that." RN-B verified when ng is from a lab draw the area a second time when removing to further documentation or  c.m. the director of nursing expectation of all resident wed and monitored with the record regardless if the The DON stated further that Coumadin should be more the procedure of the procedure o		32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING			06/0	09/2016
	PROVIDER OR SUPPLIER			24	TREET ADDRESS, CITY, STATE, ZIP CODE 400 ST FRANCIS DRIVE RECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	The facility policy tit Assessment and ca identified the object resident needs, desassessment data a outcomes on a sch 483.25 PROVIDE OF HIGHEST WELL B.  Each resident must provide the necession maintain the high mental, and psychological policy and provide the necession maintain the high mental, and psychological policy time.	and symptoms of bleeding.  led Resident MDS 3.0 are plan reviewed 4/15 ive as follows: To assess sign interventions based on and evaluate interventions eduled and as needed basis. CARE/SERVICES FOR	F 2				7/18/16
	by: Based on observatoreview, the facility for assessed, monitored implemented to predict residents (R41) revision conditions.  Findings include: R41's quarterly Min 3/18/16, identified For congestive heart fairregular pulse, Alzh	ion, interview and document ailed to ensure bruising was ed, and interventions vent further bruising for 1 of 3 iewed for non-pressure related immum Data Set (MDS) dated 841's diagnoses included illure, atrial fibrillation (a-fib), neimer disease/ dementia, with impairment and daily use of edication.			Facility RN will audit the care pland identified resident on Coumadin the and place interventions regarding assessing, monitoring and further by prevention in the care plan.  Facility RN will audit all care plans or resident's on Coumadin therapy entitle interventions for assessing, monitoring, and further bruising prevention are care planned for. Coumadin care plan audit schedule implemented by the DON. Initially a plans that affect resident's on Coumadits by the designated RN will be on all new admissions or residents	erapy oruising of all suring e will be all care nadin ngoing done	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06/	09/2016	
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 309	The physicians ord Coumadin orders of Sunday, Tuesday, and Saturday, 1.25 R41's care plan day Category: Anticoag Coumadin for atrial for s/s (signs and sidentified s/s of bled) On 6/6/16, at 7:30 phave a dark purple back of the right had diagonally from R4 above the wrist. The during observations 6/8/16, at 11:33 p.n. Review of R41's prothrough 6/9/16, did bruising during this term care plan with 5/16/16, did not incobruising. The facilit Healed Skin and Withrough 6/9/16, did documentation of book on 6/9/16, at 1:28 proverified bathing R4 bathing duties including bruising to NA-A indicated R4. Tuesday by anothe should have had a	ers dated 6/10/16, identified of 2.5 milligrams (mg) daily Wednesday, Thursday, Friday mg Monday.  Ited active 2/4/15, included, ulant Therapy Alert. Problem: fibrillation. Approach: Monitor ymptoms) of bleeding. The eding included bruising.  D.m. R41 was observed to to black oblong bruise on the end. The bruise extended end. The bruise extended ends index finger knuckle to just the bruise remained the same is on 6/7/16, at 2:00 p.m.; in.; and 6/9/16, at 10:42, a.m ogress notes dated 3/1/16, not identify R41 had any time. Review of the short entries dated 9/1/15, through lude any documentation of y printed computer form titled yound Log dated 7/1/15, not include any	F 309	are on Coumadin for the next question to the time, findings will be brought Quality Assurance Committee for recommendation. Education to a and licensed staff will be done or Care Guidelines.  Audits will ensure that care plans residents on Coumadin therapy is proper interventions for assessin monitoring and further prevention regarding bruising. Further educing staff will be done when audits she incomplete care plans.  Overall responsibility is the DON	to the further all CNA's a Skin of have g, ation to bow		

	O PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245265	B. WING _	·····	06	/09/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	(LPN)-A indicated so bruising would be nowith size and color. The bruise would be plan, the details wo physician, the famil bruise would be folleach bath day until did have a large daright hand, received have documentation. On 6/9/16, at 1:41 proverified staff was exinterventions for recresidents were to have week on bath day a reviewed by the number of the commentation of Formal alaboratory blood and Friday from the indicated the bruise may have come frowerified no docume found.  On 6/9/16, at 1:54 proverified no docume found.  Some of the commentation of the source of bruising for the source of	o.m. licensed practical nurse skin conditions including neasured and documented in the skin and wound book. e added to the short term care uld be faxed to the primary y would be notified and the lowed and documented on resolved. LPN-A verified R41 rk bruise on the back of the d Coumadin daily and did not n regarding this bruise.  O.m. registered nurse (RN)-B expected to follow the care plan sident care. RN-B identified all ave skin reviewed once a and any reported skin issues rse. RN-B verified no R41's bruising was found.  O.m. LPN-A identified R41 had draw on the prior Wednesday back of the right hand. LPN-A on the back of R41's hand m these procedures; however ntation of the bruise was  O.m. RN-B verified the PT/INR est) for Coumadin use dated thich was longer than R41's 2.3. RN-B indicated the bruise ld have been from this lab "We do not do any skin and or that." RN-B verified when ng is from a lab draw the area a second time when removing	F 30				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245265	B. WING		06	/09/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	the band-aid, with no monitoring.  On 6/9/16, at 2:44 properties to be review documentation in the cause was known. The residents receiving closely monitored because of bleeding PT/INR reading ind therapeutic goal and monitored for signs.  The facility policy tit revised 10/10, incluing Home will be ensure that all skin.	ge 10 no further documentation or  o.m. the director of nursing expectation of all resident wed and monitored with the record regardless if the The DON stated further that Coumadin should be more recause it was a high risk drug good. The DON verified a higher icated it was out of the document was out of the document	F3	09			

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PRINTED: 07/01/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - MAIN BUILDING 245265 B. WING 06/08/2016 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 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey St Francis Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101 Or by e-mail to: (X6) DATE

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

TITLE

Electronically Signed

06/30/2016

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.

Facility ID: 00818

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - MAIN BUILDING		TE SURVEY MPLETED
		245265	B WING		06	/08/2016
	PROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CO 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Continued From particles and Angela. Kappenma  THE PLAN OF CODEFICIENCY MUSTOLLOWING INFO  1. A description of to correct the defice  2. The actual, or possible for corprevent a reoccurrent and are considered as a separated from St. 3- hour fire barriers zones with 1-hour.	age 1 state.mn.us n@state.mn.us  PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency.  Inveyed as one building. Is part of the St Francis is. It was built in 2005, is a ithout a basement and was Type V (111) construction. It is Francis Healthcare Center with is and is divided into 4 smoke	KC	DEFICIENCY)	PPROPRIATE	
	automatic fire springuick response springuick response springuick response springuick response springuick response with National Installation of Springuick response detectors the sample of the springuick response springuick re	nkler system equipped with rinkler heads. The Automatic em has been installed in IFPA 13 Standard for the nkler Systems 1999 edition. manual fire alarm system with hroughout the corridor system, ne corridors, and common earm System has been installed in NFPA 72 "The National Fire edition. Hazardous areas have	_			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 02 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		245265	B, WING			06/	08/2016
	PROVIDER OR SUPPLIER			2400 ST F	DDRESS, CITY, STATE, ZIP CODE RANCIS DRIVE NRIDGE, 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 SHOI OSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	alarm system and a detectors that alarr nurse's station that	age 2 ctors that are into the fire all sleeping rooms have smoke n outside the rooms and at the serves that room in e Minnesota State Fire Code	K	00			G.
K 022	The requirement a NOT MET.	apacity of 80 beds and had a time of the survey. t 42 CR, Subpart 483.70(a) is	K	22			6/23/16
SS=E	readily visible signs way to reach exit is occupants. Doors, not a way of exit th an exit have a sign 18.2.10.1, 19.2.10. This STANDARD Based on observa facility has failed to non-required exit does not lead to th with NFPA 101 (00 7.10.8.1. These donegatively affect all by causing confusi	all be marked by approved, in all cases where the exit or not readily apparent to the passages or stairways that are at are likely to be mistaken for designating "No Exit". 7.10, 1 is not met as evidenced by: tion and staff interview, the properly identify one loor leading to the exterior that e public way in accordance accordance of sections 7.10.1.7 and efficient practices could a residents, staff and visitors, on in locating an exit from the lic way in the event of an		on 6- sign i	o Exit" sign was installed o .23-16. Responsibility to m remains there is the Directorations.	onitor this	
	on 06/08/2016 obs	between 9:45 am to 2:30 pm ervations and staff interview or door leading to a courtyard een the railway wing and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION 6 <b>02 - MAIN BUILDING</b>		E SURVEY PLETED
		245265	B. WING		06/	08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2400 ST FRANCIS DRIVE  BRECKENRIDGE, MN 56520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 022	Continued From pa central common ar- sign.	age 3 ea did not have a "No Exit"	K 022			
K 038 SS=B	Facilities Manager. NFPA 101 LIFE SA  Exit access is so at accessible at all time.	rranged that exits are readily nes in accordance with 7.1.	K 038	3		6/20/16
	Based on observa determined that the several exit dischar accordance with N edition, Section 7.1 this deficient practi	is not met as evidenced by: tions and staff interview, it was e facility failed to maintain 1 of rge walking surfaces in FPA 101 Life Safety Code (00) 1.6.2. During an evacuation ce could affect an ount of staff and visitors.		A plate was ordered and installe 6-20-16 to ramp this elevation of the plate will adjust self if sidew more. Monitoring of sidewalk such throughout the facility has been the Environment Tours Checklish be the responsibility of the Plan Operations Director.	lifference. valk settles ettling added to st. This will	
	on 06/08/2016 obs revealed a sidewal exceeded the allow ramp is required. T	between 9:45 am to 2:30 pm ervations and staff interview k elevation difference that ved amount before a bevel or his deficiency was located at of the Railway wing which was of inspection.				
K 062 SS=E	Facilities Manager NFPA 101 LIFE SA Automatic sprinkle maintained in relial	AFETY CODE STANDARD  r systems are continuously ble operating condition and are	K 06	2		6/23/16
	4.6.12, NFPA 13, N This STANDARD	ed periodically. 18.7.6, 19.7.6, NFPA 25, 9.7.5 is not met as evidenced by: ations and staff interview, the		Deflector was cleaned of paint	. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 02 - MAIN BUILDING			SURVEY PLETED
		245265	B. WING		06/0	08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 5652	ZIP 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 062	automatic sprinkler NFPA 101 Life Safe 9.7.1.1, NFPA 13 I Systems (99), and Inspection, Testing Based Fire Protect deficient practice deficient practice desprinkler system is fully operational in negatively affect 40 undetermined amount of the facility tour on 06/08/2016 observealed a sprinkler	age 4 a properly maintain the system in accordance with ety Code (00), Section 18.3.5, nstallation of Sprinkler NFPA 25 Standard for the and Maintenance of Water ion Systems, (98). This loes not ensure that the fire functioning properly and is the event of a fire and could of the 80 residents and an ount of staff and visitors.  between 9:45 am to 2:30 pm ervations and staff interview er head that had paint on the et in the Riverwalk A dining	KO	painting done in the futus prinkler heads will be in maintenance staff when are completed. This will responsibility of the Plar Director	nspected by painting projects be the	
<b>K</b> 144 SS=F	Facilities Manager NFPA 101 LIFE SA Generators inspect under load for 30 r in accordance with 3-4.4.1 and 8-4.2 ( 110) This STANDARD Based on review of the facility failed to generator in accor NFPA 110 - 1999 e edition, section 3-4 could affect the sa	tice was verified by the AFETY CODE STANDARD  ted weekly and exercised minutes per month and shall be NFPA 99 and NFPA 110.  NFPA 99), Chapter 6 (NFPA is not met as evidenced by: of records and staff interview, maintain the emergency dance with the requirements of edition and NFPA 99 - 1999 1.1.1.2. This deficient practice fety of all 80 residents and an ount of staff and visitors.	К1	The monthly generator updated to document the on 6-23-16. This is the the Plant Operations Di	ne cool down cycle responsibility of	6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED					
		245265	B. WING		06/08/2016			
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE  2400 ST FRANCIS DRIVE  BRECKENRIDGE, MN 56520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETIO			
K 144	on 06/08/2016 rec revealed the gene being logged on th	between 9:45 am to 2:30 pm ord review and staff interview rator cool down cycle was not ne monthly reports.	K 144					



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 24, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5265025

Dear Mr. Nelson:

The above facility was surveyed on June 6, 2016 through June 9, 2016 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00818	B. WING		06/0	9/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST FRAN	ICIS HOME		FRANCIS DR NRIDGE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the management of the schedule of the minnesota Department of the schedule of the minnesota Department of the schedule of	nether a violation has been compliance with all rule provided at the tag					
	number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					

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

06/30/16 **Electronically Signed** 

STATE FORM 6899 GUFD11 If continuation sheet 1 of 14

TITLE

(X6) DATE

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	PLETED
		00818	B. WING		06/0	9/2016
	PROVIDER OR SUPPLIER	2400 ST F	DRESS, CITY, S FRANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically, is necessary for Starenter the word "correct. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be state and replaces the "Incommon statute of common statute of common statute of common state	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the ent of Health.  In the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, ewhen they will be completed. The ent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for the ent of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection.  IRD THE HEADING OF THE I WHICH STATES, NOF CORRECTION." THIS ERAL DEFICIENCIES ONLY.	2 000			

Minnesota Department of Health STATE FORM

GUFD11 If continuation sheet 2 of 14

AND PLAN	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		
		00818	B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ST FRAN	ICIS HOME		RANCIS DR			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	IRIDGE, MN	PROVIDER'S PLAN OF CORRECTION	)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
2 000	Continued From page 2		2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 565	5 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			7/18/16
	Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.					
	by: Based on observati review, the facility fa interventions were f	ent is not met as evidenced on, interview, and document ailed to ensure the care plan ollowed for 1 of 2 residents o received an anticoagulant		Corrected		
	Findings include:					
	3/18/16, identified F congestive heart fai irregular pulse, Alzh	imum Data Set (MDS) dated R41's diagnoses included lure, atrial fibrillation (a-fib), neimer disease/ dementia, with impairment and daily use of edication.				
	Category: Anticoage Coumadin for atrial for s/s (signs and sy identified s/s of blee	ed active 2/4/15, included, ulant Therapy Alert. Problem: fibrillation. Approach: Monitor (mptoms) of bleeding. The eding included bruising.				

Minnesota Department of Health

STATE FORM 6899 GUFD11 If continuation sheet 3 of 14

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520   (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 3  have a dark purple to black oblong bruise on the back of the right hand. The bruise extended	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI LAN OF CORRECTION IDENTIFICATION NO	IMDED: '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2400 ST FRANCIS DRIVE  BRECKENRIDGE, MN 56520   (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 3  have a dark purple to black oblong bruise on the back of the right hand. The bruise extended  STREET ADDRESS, CITY, STATE, ZIP CODE  2400 ST FRANCIS DRIVE  BRECKENRIDGE, MN 56520  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE)  2 565					
ST FRANCIS HOME  2400 ST FRANCIS DRIVE BRECKENRIDGE, MN 56520  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 565  Continued From page 3  have a dark purple to black oblong bruise on the back of the right hand. The bruise extended  2 565  Continued From page 3  have a dark purple to black oblong bruise on the back of the right hand. The bruise extended	00818	B. WING		06/09/2016	
ST FRANCIS HOME   BRECKENRIDGE, MN 56520	OF PROVIDER OR SUPPLIER		CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 565  Continued From page 3  have a dark purple to black oblong bruise on the back of the right hand. The bruise extended	ANCIS HOME				
have a dark purple to black oblong bruise on the back of the right hand. The bruise extended	(EACH DEFICIENCY MUST BE PRECEDED BY	FULL PREFIX (E	EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROI	LD BE COMPLETE	
diagonally from R41's index finger knuckle to just above the wrist. The bruise remained the same during observations on 67716, at 2:00 p.m.; 6/8/16, at 11:33 p.m.; and 6/9/16, at 10:42, a.m  Review of R41's progress notes dated 3/1/16, through 6/9/16, did not identify R41 had any bruising during this time. Review of the short term care plan with entries dated 9/1/15, through 5/16/16, did not include any documentation of bruising. The facility printed computer form titled Healed Skin and Wound Log dated 7/1/15, through 6/9/16, did not include any documentation of bruising.  On 6/9/16, at 1:28 p.m. nursing assistant (NA)-A verified bathing R41 weekly. NA-A identified the bathing duties included a thorough review of R41's skin and a report of any skin conditions including bruising to the charge nurse on duty. NA-A indicated R41 had a bath completed on Tuesday by another staff member and there should have had a skin review at that time. NA-A stated, "I haven't noticed a bruise on [R41's] hand but she does bruise easily".  On 6/9/16, at 1:34 p.m. licensed practical nurse (LPN)-A verified R41 did have a large dark bruise on the back of the right hand, received Coumadin daily and did not have documentation regarding this bruise.  On 6/9/16, at 1:41 p.m. registered nurse (RN)-B verified staff was expected to follow the care plan interventions for resident care. RN-B verified no documentation of R41's bruising was found.	have a dark purple to black oblong bruiback of the right hand. The bruise extendiagonally from R41's index finger knu above the wrist. The bruise remained the during observations on 6/7/16, at 2:00 p 6/8/16, at 11:33 p.m.; and 6/9/16, at 10 Review of R41's progress notes dated through 6/9/16, did not identify R41 had bruising during this time. Review of the term care plan with entries dated 9/1/18/5/16/16, did not include any documentat bruising. The facility printed computer of Healed Skin and Wound Log dated 7/1 through 6/9/16, did not include any documentation of bruising.  On 6/9/16, at 1:28 p.m. nursing assistative verified bathing R41 weekly. NA-A identified bathing duties included a thorough review R41's skin and a report of any skin continuluting bruising to the charge nurse of NA-A indicated R41 had a bath completo Tuesday by another staff member and should have had a skin review at that the stated, "I haven't noticed a bruise on [I hand but she does bruise easily".  On 6/9/16, at 1:34 p.m. licensed practice (LPN)-A verified R41 did have a large of on the back of the right hand, received daily and did not have documentation rethis bruise.  On 6/9/16, at 1:41 p.m. registered nursing verified staff was expected to follow the interventions for resident care. RN-B verified RN-B	se on the nded ckle to just he same o.m.; 42, a.m  3/1/16, I any short of the short of the same of t	DEL IOIENCT)		

Minnesota Department of Health

STATE FORM GUFD11 If continuation sheet 4 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	00818	B. WING		06/0	9/2016
NAME OF PROVIDER OR SUPE	2400 ST F	DRESS, CITY, S' FRANCIS DRI NRIDGE, MN			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
and Friday from indicated the beamy have compared to be found.  On 6/9/16, at 1 on R41's hand draw. RN-B standard the band-aid, where the band-aid the band-aid the consideration of the band-aid the consideration of the band-aid the band-	m page 4  cood draw on the prior Wednesday in the back of the right hand. LPN-A cruise on the back of R41's hand the from these procedures; however reumentation of the bruise was  1:54 p.m. RN-B indicated the bruise would have been from the lab ated,"We do not do any skin and ring for that." RN-B verified when bruising is from a lab draw the area and at a second time when removing with no further documentation or  1:44 p.m. the director of nursing the expectation of all resident eviewed and monitored with in the record regardless if the bwn. The DON stated further that iving Coumadin should be more red because it was a high risk drug red indicated it was out of the all and would expect R41 to be signs and symptoms of bleeding.  icy titled Resident MDS 3.0 and care plan reviewed 4/15 abjective as follows: To assess a cheduled and as needed basis.  METHOD OF CORRECTION: In nursing (DON) or designee could acies and procedures related to amplement resident care plans. The	2 565			

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STATE FORM GUFD11 If continuation sheet 5 of 14

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	random audits to er	or designee could complete nsure ongoing compliance and to the quality assurance				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			7/18/16
	receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and any home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa assessed, monitore implemented to pre residents (R41) rev skin conditions.	ent is not met as evidenced on, interview and document ailed to ensure bruising was ed, and interventions vent further bruising for 1 of 3 iewed for non-pressure related		Corrected		
		imum Data Set (MDS) dated R41's diagnoses included				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00818	B. WING		06/0	9/2016
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST FRANCIS HO	ИΕ		RANCIS DR IRIDGE, MN			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
conges irregula modera an anti The ph Couma Sunday and Sa R41's of Categor Couma for s/s identified On 6/6 have a back of diagon above during 6/8/16, Review through bruising term ca 5/16/16 bruising Healed through docum On 6/9 verified bathing R41's s	ar pulse, Alzlate cognitive coagulant mysicians ord din orders of turday, 1.25 care plan dairy: Anticoagudin for atrial (signs and sed s/s of bleef the right haally from Rathe wrist. Thobservations at 11:33 p.m. of R41's prof R41's	illure, atrial fibrillation (a-fib), heimer disease/ dementia, with impairment and daily use of edication.  ers dated 6/10/16, identified of 2.5 milligrams (mg) daily Wednesday, Thursday, Friday mg Monday.  ted active 2/4/15, included, rulant Therapy Alert. Problem: fibrillation. Approach: Monitor ymptoms) of bleeding. The eding included bruising.  p.m. R41 was observed to to black oblong bruise on the ruland. The bruise extended this index finger knuckle to just e bruise remained the same on 6/7/16, at 2:00 p.m.; n.; and 6/9/16, at 10:42, a.m ogress notes dated 3/1/16, not identify R41 had any time. Review of the short entries dated 9/1/15, through lude any documentation of y printed computer form titled found Log dated 7/1/15, not include any	2 830	BEI MILNOT)		

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STATE FORM GUFD11 If continuation sheet 7 of 14

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION (X3) DATE SU COMPLE		
		00818	B. WING		06/0	9/2016
	PROVIDER OR SUPPLIER	2400 ST F	DRESS, CITY, S FRANCIS DRI NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Tuesday by another should have had a stated, "I haven't in hand but she does  On 6/9/16, at 1:34 p (LPN)-A indicated should be nowith size and color. The bruise would be plan, the details wo physician, the famil bruise would be folleach bath day until did have a large daright hand, received have documentation.  On 6/9/16, at 1:41 p verified staff was exinterventions for respected by the number of the week on bath day a reviewed by the number of the color of the bruise may have come frowerified no docume found.  On 6/9/16, at 1:54 p (blood clotting lab to the bruise may have come frowerified no docume found.	r staff member and there skin review at that time. NA-A oticed a bruise on [R41's] bruise easily".  o.m. licensed practical nurse kin conditions including neasured and documented in the skin and wound book. The added to the short term care uld be faxed to the primary yould be notified and the owed and documented on resolved. LPN-A verified R41 rk bruise on the back of the discounseling this bruise.  o.m. registered nurse (RN)-B expected to follow the care plantage and any reported skin issues and any rep		DEFICIENCY		
	6/1/16, was 2.95, w therapeutic goal of on R41's hand wou	hich was longer than R41's 2.3. RN-B indicated the bruise Id have been from this lab "We do not do any skin and				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00818	B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR			
(VA) ID	QUIMMA DV QTA	TEMENT OF DEFICIENCIES	IRIDGE, MN	PROVIDER'S PLAN OF CORRECTI	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	the source of bruisi would be looked at the band-aid, with r monitoring.	or that." RN-B verified when ng is from a lab draw the area a second time when removing to further documentation or				
	(DON) verified the obruises to be review documentation in the cause was known. residents receiving closely monitored because of bleeding PT/INR reading indicate the trapeutic goal and the rapeutic goal and the respective to the trapeutic goal and trapeutic goal goal goal goal goal goal goal goal	o.m. the director of nursing expectation of all resident wed and monitored with the record regardless if the The DON stated further that Coumadin should be more recause it was a high risk drug g. The DON verified a higher icated it was out of the d would expect R41 to be and symptoms of bleeding.				
	revised 10/10, inclu Nursing Home will I ensure that all skin	led Skin Care Guidelines, ded the objective: "St. Francis have a process in place to conditions are reported, hted, and evaluated in a timely				
	director of nursing (implement policies non-pressure relate with anti-coagulant all appropriate staff or designee could censure ongoing corresults to the quality					
	(21) days.	R CORRECTION: Twenty-one				

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	AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00818	B. WING		06/0	09/2016
_	PROVIDER OR SUPPLIER	2400 ST	DDRESS, CITY, S FRANCIS DR NRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 9	21805			
	MN St. Statute 144. Residents of HC Farsidents of HC Farsidents have the courtesy and respect employees of or perhealth care facility.  This MN Requirements by:	651 Subd. 5 Patients &	21805	Corrected		7/18/16
	review the facility fadignified manner foutilized a transfer between Einding include:  R10's annual Minim 3/4/16, identified Rincluded: diabetes, The MDS identified impairment and requone staff for bed malso indicated R10 one staff to walk in to walk in corridor at R10's current care R10 had a self care living (ADL's) relate lack of follow through plan indicated R10 use of a front whee frequent cueing or wher walker, which recare plan also indicated R10 indica	illed to provide services in a r 1 of 3 residents (R10) who				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
		00818	B. WING		06/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAN	ICIS HOME		RANCIS DR			
			IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 10	21805			
	ease with transfers	when up.				
	On 6/6/16, at 4:55 pdining room eating independently with at tables around he belt fastened around R10 remained seat and continued to he around her waist ar residents seated in assistant (NA)-C was her to stand using the around her waist. Beack to her room us p.m. through the en R10 was seated in the transfer belt still. On 6/7/16, at 2:54 precliner in her room around her waist. A room walking indepthe transfer belt fas 3:47 p.m. R10 stooreading a magazine fastened around her waist. On 6/8/16, at 7:33 apersonal cares, NA around R10's waist independently, dow At 8:01 a.m. R10 windependently back	o.m. R10 was seated in the her supper meal several other residents seated reating. R10 had a transfer dher waist area. At 6:01 p.m. ed at the dining room table ave the transfer belt fastened ea with several other the dining room area. Nursing alked up to R10, and assisted he transfer belt fastened at 0 proceeded to walk alone, sing her FWW. From 6:55 and of observation at 7:43 p.m. her recliner in her room, with a fastened around the waist.  o.m. R10 was seated in her with the transfer belt fastened at 3:24 p.m. R10 was in her rendently with her FWW and tened around her waist. At do next to her table in her room with the transfer belt in her room with the transfer belt in her room as with the transfer belt in waist.				
	breast/rib cage area transfer belt remain breast/rib cage area	a. At 8:15 a.m. with the ling fastened under R10's a, Licensed practical nurse la to to stand from her recliner.				
		ndently with her FWW to the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUI COMPLET	
		00818	B. WING		06/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRAM	NCIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	LPN-C to sit down in At 8:30 a.m. R10 confastened under her dining room table. In the dining room table, in the dining room table, in the dining room. In her recliner and obelt fastened up un At 11:30 a.m. R10 windependently with belt fastened under 1:00 p.m. R10 was at a magazine with under her breast/rite remained in her recommended in her she did not like it." up and then I have spoils my whole day she did not like the all the time. Staff hat tell her she wouldn' rather not have it on to walk independent ambulation.  On 6/9/16, at 1:35 pronfirmed R10 work all day, she was incurrent was incurrent recommended in her FWW and the place." NA-E incassistance to get in felt R10 was not a fat transfer belt on be plan, but didn't known and the place."	as given verbal cues from	21805			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00818	B. WING		06/0	9/2016
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST FRANC	CIS HOME		RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
	on 6/9/16 at 1:39 p. confirmed R10 word all day and confirmed Glan. RN-A indicate get in and out of chatching in the morning transfer herself at tile wore the transfer betasier for us to get chairs." RN-A felt R was up for the day, ambulation using he was not aware that belt. RN-A indicted it transfer belt around for her to have it on COn 6/9/16, at 2:22 p. (DON) confirmed R consistently all day. The DON also state would never do it." Independent with arthe unit. The DON addignified to have the R10's breast/rib cage that would be uncorrected by the undar patients/Clients/Responsibilities, increasing must with coyou in a manner and confirmed and manner and confirmed to the coyou in a manner and confirmed to the confirmed to the coyou in a manner and confirmed to the conf	elt all the time. NA-E stated "I vear one all the time."  .m. registered nurse (RN)-A et the transfer belt consistently ed it was her current care ed R10 needed assistance to airs and with transfers first g. RN-A also indicated R10 did mes and that was why she elt all the time. RN-A stated "its her up and down from the 10 was not a fall risk once she she was independent with er FWW. RN-A indicted she R10 did not want to wear the if R10 did not want to wear the if R10 did not want the later, then it was not dignified one.  In the director of nursing 10 wore the transfer belt. The DON stated "we do use help her up with transfers." ed "if it bothered a resident, I The DON confirmed R10 was indulation in her room and on also indicated it was not e transfer belt riding up under ge area and stated "potentially infortable for the resident."  Ited, facility policy titled sidents Rights and dicated under Dignity: "the urtesy promote and care for denvironment that maintains dignity and respect in full	21805			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00818	B. WING		06/0	9/2016
	PROVIDER OR SUPPLIER	2400 ST F	DRESS, CITY, S RANCIS DR IRIDGE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	SUGGESTED MET director of nursing (implement policies dignified care of restransfer belts. The I these systems. The complete random a compliance and repassurance group.	ge 13 (HOD OF CORRECTION: The (DON) or designee could and procedures related to the sidents such as the use of DON could educate all staff on a DON or designee could udits to ensure ongoing port these results to the quality of CORRECTION: Twenty-one	21805			

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