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.
(L1) **245265**

2.STATE VENDOR OR MEDICAID NO.
(L2) **003543200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST FRANCIS HOME**
(L4) **2400 ST FRANCIS DRIVE**
(L5) **BRECKENRIDGE, MN** (L6) **56520**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 07/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/22/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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 Meath

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

MDH
Minnesota
Department
of Health

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 S5265025

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 Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245265		7/22/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 07/18/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/18/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 07/18/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TA/mm	DATE 07/29/2016	SIGNATURE OF SURVEYOR 29433	DATE 07/22/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245265 Y1	A. Building 02 - MAIN BUILDING B. Wing Y2	7/18/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	07/29/2016	36536	07/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GUFD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00818

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(L1) **245265**

2.STATE VENDOR OR MEDICAID NO.
(L2) **003543200**

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(L3) **ST FRANCIS HOME**
(L4) **2400 ST FRANCIS DRIVE**
(L5) **BRECKENRIDGE, MN** (L6) **56520**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Tammy Williams, HFE NEII — 07/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/22/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
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3. Both of the Above :

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06/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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

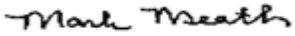
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a dignified manner for 1 of 3 residents (R10) who utilized a transfer belt. Finding include: R10's annual Minimum Data Set (MDS) dated 3/4/16, identified R10 had diagnoses which included: diabetes, Parkinson's, and dementia. The MDS identified R10 had moderate cognitive impairment and required extensive assistance of one staff for bed mobility and transfers. The MDS	F 241	Facility assessed the identified resident that was wearing a gait belt at all times when up for necessity. The care plan was changed to reflect that gait belt is not needed at all times prior the surveyors leaving our facility. Facility will assess all residents that wear a gait belt at all times when up for necessity and ensure that dignity is being respected. Care plan documentation will be in place for the necessity and that the resident's safety and dignity is respected. During the instance where a resident	7/18/16

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

Electronically Signed | 06/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ B. WING _____	06/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 also indicated R10 needed limited assistance of one staff to walk in her room, supervision of staff to walk in corridor and on and off the unit. R10's current care plan dated 11/5/11, indicated R10 had a self care deficit of activities of daily living (ADL's) related to weakness, confusion, lack of follow through and Parkinson's. The care plan indicated R10 walked independently with the use of a front wheeled walker (FWW), needed frequent cueing or would become lost, forgetting her walker, which required staff to retrieve. The care plan also indicated R10 would self transfer needing staff assistance with transfers to get in and out of chairs and utilized a transfer belt to ease with transfers when up. On 6/6/16, at 4:55 p.m. R10 was seated in the dining room eating her supper meal independently with several other residents seated at tables around her eating. R10 had a transfer belt fastened around her waist area. At 6:01 p.m. R10 remained seated at the dining room table and continued to have the transfer belt fastened around her waist area with several other residents seated in the dining room area. Nursing assistant (NA)-C walked up to R10, and assisted her to stand using the transfer belt fastened around her waist. R10 proceeded to walk alone, back to her room using her FWW. From 6:55 p.m. through the end of observation at 7:43 p.m. R10 was seated in her recliner in her room, with the transfer belt still fastened around the waist. On 6/7/16, at 2:54 p.m. R10 was seated in her recliner in her room with the transfer belt fastened around her waist. At 3:24 p.m. R10 was in her room walking independently with her FWW and the transfer belt fastened around her waist. At	F 241	would wear a gait belt at all times, the resident's dignity will be respected. Any resident using a gait belt at all times will be assessed on a daily basis to determine whether or not they feel comfortable wearing the belt. Education will be provided to staff on gait belts related to dignity concerns. We currently have no residents wearing 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 PM for licensed staff to ask resident if they are comfortable with wearing the gait belt at all times. Audits will be conducted weekly for dignity and reviewed at the QA&A committee meetings. Overall responsibility is the DON.	

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F 241	Continued From page 2	F 241		

3:47 p.m. R10 stood next to her table in her room reading a magazine with the transfer belt fastened around her waist.

On 6/8/16, at 7:33 a.m. during observation of personal cares, NA-D placed a transfer belt around R10's waist. R10 then walked independently, down the hallway using her FWW. At 8:01 a.m. R10 was observed ambulating independently back to her room using her FWW. The transfer belt was fastened up under her breast/rib cage area. At 8:15 a.m. with the transfer belt remaining fastened under R10's breast/rib cage area, Licensed practical nurse (LPN)-C assisted R10 to stand from her recliner. R10 walked independently with her FWW to the dining room. R10 was given verbal cues from LPN-C to sit down in her chair.
At 8:30 a.m. R10 continued have the transfer belt fastened under her breast/rib cage area at the dining room table. Several other residents were in the dining room. At 10:00 a.m. R10 was seated in her recliner and continued to have the transfer belt fastened up under her breast/rib cage area. At 11:30 a.m. R10 was walking around her room independently with her FWW with the transfer belt fastened under her breast/rib cage area. At 1:00 p.m. R10 was seated in her recliner looking at a magazine with the transfer belt fastened under her breast/rib cage area. At 2:45 p.m. R10 remained in her recliner with the transfer belt on.

On 6/7/16, at 2:56 p.m. R10 stated staff told her she had to wear the transfer belt all the time so she did not fall. R10 stated "they think this belt around my belly will keep me from falling." R10 said "I don't like it." R10 stated "Oh I get dressed up and then I have to put that belt on me and that spoils my whole day." R10 indicated she told staff

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F 241	Continued From page 3	F 241		

she did not like the transfer belt around her waist all the time. Staff has not removed the belt, then tell her she wouldn't want to fall. R10 stated "I'd rather not have it on." R10 indicated she was able to walk independently with the FWW for ambulation.

On 6/9/16, at 1:35 p.m. nursing assistant (NA)-E confirmed R10 wore the transfer belt consistently all day, she was independent with ambulation using her FWW and stated "she will walk all over the place." NA-E indicated R10 needed staff assistance to get in and out of the chair and she felt R10 was not a fall risk. NA-E stated R10 had a transfer belt on because it was on the care plan, but didn't know why R10 had it on all the time. NA-E felt it was not dignified to have R10 wear her transfer belt all the time. NA-E stated "I would not want to wear one all the time."

On 6/9/16 at 1:39 p.m. registered nurse (RN)-A confirmed R10 wore the transfer belt consistently all day and confirmed it was her current care plan. RN-A indicated R10 needed assistance to get in and out of chairs and with transfers first thing in the morning. RN-A also indicated R10 did transfer herself at times and that was why she wore the transfer belt all the time. RN-A stated "its easier for us to get her up and down from the chairs." RN-A felt R10 was not a fall risk once she was up for the day, she was independent with ambulation using her FWW. RN-A indicted she was not aware that R10 did not want to wear the belt. RN-A indicted if R10 did not want the transfer belt around her, then it was not dignified for her to have it on.

On 6/9/16, at 2:22 p.m. the director of nursing (DON) confirmed R10 wore the transfer belt

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F 241	Continued From page 4 consistently all day. The DON stated "we do use the transfer belt to help her up with transfers." The DON also stated "if it bothered a resident, I would never do it." The DON confirmed R10 was independent with ambulation in her room and on the unit. The DON also indicated it was not dignified to have the transfer belt riding up under R10's breast/rib cage area and stated "potentially that would be uncomfortable for the resident." Review of the undated, facility policy titled Patients/Clients/Residents Rights and Responsibilities, indicated under Dignity: "the facility must with courtesy promote and care for you in a manner and environment that maintains and enhances your dignity and respect in full recognition of your individuality".	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan interventions were followed for 1 of 2 residents (R41) reviewed, who received an anticoagulant medication. Findings include: R41's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R41's diagnoses included	F 282	The care plan was updated to reflect anticoagulant therapy for resident R41. Updated our check off sheet for skin & wound, bruises, and skin tears to state: bruises that are explainable need to be documented under quick notes in chart. Bruises that are unexplainable, associated with a hematoma, resident on Coumadin therapy, in an odd place or are suspicious looking need to be	7/18/16

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F 282	Continued From page 5 congestive heart failure, atrial fibrillation (a-fib), irregular pulse, Alzheimer disease/ dementia, with moderate cognitive impairment and daily use of an anticoagulant medication. R41's care plan dated active 2/4/15, included, Category: Anticoagulant Therapy Alert. Problem: Coumadin for atrial fibrillation. Approach: Monitor for s/s (signs and symptoms) of bleeding. The identified s/s of bleeding included bruising. On 6/6/16, at 7:30 p.m. R41 was observed to have a dark purple to black oblong bruise on the back of the right hand. The bruise extended diagonally from R41's index finger knuckle to just above the wrist. The bruise remained the same during observations on 6/7/16, 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".	F 282	investigated, measured, and documented under skin & wound for further monitoring/follow up. An audit will be done on care plans of residents that have potential indications from check off sheet that could be vulnerable to skin issues. Updated check off sheets, which will be easily assessable in the nurse's station for quick reference and charting clarification for when a bruise is found on a resident. Licensed staff were educated on 6-15-16 meeting regarding expectations and check off sheets expectations. All licensed staff were emailed the minutes from the June meeting so those not in attendance know expectations. updated check off sheets placed in nurse's station on each unit for quick reference and charting clarification for when a bruise is found on a resident. Bruising audits will be implemented by the DON and completed by licensed staff. Audit schedule of 4 residents weekly X 4, then 4 residents monthly, along with random audits and then they will be brought to the Quality Assurance Committee for further recommendation. Audits will ensure that bruises are documented correctly per policy. Staff will be educated when audits show incomplete documentation, and findings will be reported to Quality Assurance Committee. Overall responsibility is the DON	

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F 282	Continued From page 6 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. On 6/9/16, at 1:51 p.m. LPN-A identified R41 had a laboratory blood draw on the prior Wednesday and Friday from the back of the right hand. LPN-A indicated the bruise on the back of R41's hand may have come from these procedures; however verified no documentation of the bruise was found. On 6/9/16, at 1:54 p.m. RN-B indicated the bruise on R41's hand would have been from the lab draw. RN-B stated,"We do not do any skin and wound monitoring for that." RN-B verified when the source of bruising is from a lab draw the area would be looked at a second time when removing the band-aid, with no further documentation or monitoring. On 6/9/16, at 2:44 p.m. the director of nursing (DON) verified the expectation of all resident bruises to be reviewed and monitored with documentation in the record regardless if the cause was known. The DON stated further that residents receiving Coumadin should be more closely monitored because it was a high risk drug because of bleeding. The DON verified a higher PT/INR reading indicated it was out of the therapeutic goal and would expect R41 to be	F 282		

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F 282	Continued From page 7 monitored for signs and symptoms of bleeding. The facility policy titled Resident MDS 3.0 Assessment and care plan reviewed 4/15 identified the objective as follows: To assess resident needs, design interventions based on assessment data and evaluate interventions outcomes on a scheduled and as needed basis.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruising was assessed, monitored, and interventions implemented to prevent further bruising for 1 of 3 residents (R41) reviewed for non-pressure related skin conditions. Findings include: R41's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R41's diagnoses included congestive heart failure, atrial fibrillation (a-fib), irregular pulse, Alzheimer disease/ dementia, with moderate cognitive impairment and daily use of an anticoagulant medication.	F 309	Facility RN will audit the care plan of the identified resident on Coumadin therapy and place interventions regarding assessing, monitoring and further bruising prevention in the care plan. Facility RN will audit all care plans of all resident's on Coumadin therapy ensuring the interventions for assessing, monitoring, and further bruising prevention are care planned for. Coumadin care plan audit schedule will be implemented by the DON. Initially all care plans that affect resident's on Coumadin will be completed by 7-1-16, then ongoing audits by the designated RN will be done on all new admissions or residents that	7/18/16

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F 309	Continued From page 8 The physicians orders dated 6/10/16, identified Coumadin orders of 2.5 milligrams (mg) daily Sunday, Tuesday, Wednesday, Thursday, Friday and Saturday, 1.25 mg Monday. R41's care plan dated active 2/4/15, included, Category: Anticoagulant Therapy Alert. Problem: Coumadin for atrial fibrillation. Approach: Monitor for s/s (signs and symptoms) of bleeding. The identified s/s of bleeding included bruising. On 6/6/16, at 7:30 p.m. R41 was observed to have a dark purple to black oblong bruise on the back of the right hand. The bruise extended diagonally from R41's index finger knuckle to just above the wrist. The bruise remained the same during observations on 6/7/16, 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".	F 309	are on Coumadin for the next quarter. At that time, findings will be brought to the Quality Assurance Committee for further recommendation. Education to all CNA's and licensed staff will be done on Skin Care Guidelines. Audits will ensure that care plans of residents on Coumadin therapy have proper interventions for assessing, monitoring and further prevention regarding bruising. Further education to staff will be done when audits show incomplete care plans. Overall responsibility is the DON.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 9 On 6/9/16, at 1:34 p.m. licensed practical nurse (LPN)-A indicated skin conditions including bruising would be measured and documented with size and color in the skin and wound book. The bruise would be added to the short term care plan, the details would be faxed to the primary physician, the family would be notified and the bruise would be followed and documented on each bath day until resolved. 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 identified all residents were to have skin reviewed once a week on bath day and any reported skin issues reviewed by the nurse. RN-B verified no documentation of R41's bruising was found. On 6/9/16, at 1:51 p.m. LPN-A identified R41 had a laboratory blood draw on the prior Wednesday and Friday from the back of the right hand. LPN-A indicated the bruise on the back of R41's hand may have come from these procedures; however verified no documentation of the bruise was found. On 6/9/16, at 1:54 p.m. RN-B verified the PT/INR (blood clotting lab test) for Coumadin use dated 6/1/16, was 2.95, which was longer than R41's therapeutic goal of 2.3. RN-B indicated the bruise on R41's hand would have been from this lab draw. RN-B stated,"We do not do any skin and wound monitoring for that." RN-B verified when the source of bruising is from a lab draw the area would be looked at a second time when removing	F 309		

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F 309	Continued From page 10 the band-aid, with no further documentation or monitoring. On 6/9/16, at 2:44 p.m. the director of nursing (DON) verified the expectation of all resident bruises to be reviewed and monitored with documentation in the record regardless if the cause was known. The DON stated further that residents receiving Coumadin should be more closely monitored because it was a high risk drug because of bleeding. The DON verified a higher PT/INR reading indicated it was out of the therapeutic goal and would expect R41 to be monitored for signs and symptoms of bleeding. The facility policy titled Skin Care Guidelines, revised 10/10, included the objective: "St. Francis Nursing Home will have a process in place to ensure that all skin conditions are reported, assessed, documented, and evaluated in a timely manner."	F 309		

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

F9265025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**06/08/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey St Francis Home 01 Main Building was found not in 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:	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING **02 - MAIN BUILDING** B. WING _____	**06/08/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building. St Francis Home is part of the St Francis Healthcare Campus. It was built in 2005, is a 1-story building, without a basement and was determined to be Type V (111) construction. It is separated from St Francis Healthcare Center with 3- hour fire barriers and is divided into 4 smoke zones with 1-hour fire barriers. The entire building is completely protected by an automatic fire sprinkler system equipped with quick response sprinkler heads. The Automatic Fire Sprinkler system has been installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detectors throughout the corridor system, in areas open to the corridors, and common areas. The Fire Alarm System has been installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Hazardous areas have	K 000		

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K 000	Continued From page 2 automatic fire detectors that are into the fire alarm system and all sleeping rooms have smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 80 beds and had a census of 79 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET.	K 000		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify one non-required exit door leading to the exterior that does not lead to the public way in accordance with NFPA 101 (00) sections 7.10.1.7 and 7.10.8.1. These deficient practices could negatively affect all residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On the facility tour between 9:45 am to 2:30 pm on 06/08/2016 observations and staff interview revealed an exterior door leading to a courtyard from the link between the railway wing and the	K 022	A "No Exit" sign was installed on this door on 6-23-16. Responsibility to monitor this sign remains there is the Director of Plant Operations.	6/23/16

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K 022	Continued From page 3 central common area did not have a "No Exit" sign. This deficient practice was verified by the Facilities Manager.	K 022		
K 038 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain 1 of several exit discharge walking surfaces in accordance with NFPA 101 Life Safety Code (00) edition, Section 7.1.6.2. During an evacuation this deficient practice could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:45 am to 2:30 pm on 06/08/2016 observations and staff interview revealed a sidewalk elevation difference that exceeded the allowed amount before a bevel or ramp is required. This deficiency was located at the Northwest exit of the Railway wing which was closed at the time of inspection. This deficient condition was verified by the Facilities Manager	K 038	A plate was ordered and installed on 6-20-16 to ramp this elevation difference. The plate will adjust self if sidewalk settles more. Monitoring of sidewalk settling throughout the facility has been added to the Environment Tours Checklist. This will be the responsibility of the Plant Operations Director.	6/20/16
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the	K 062	Deflector was cleaned of paint. Any	6/23/16

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K 062	Continued From page 4 facility has failed to properly maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.3.5, 9.7.1.1, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 40 of the 80 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:45 am to 2:30 pm on 06/08/2016 observations and staff interview revealed a sprinkler head that had paint on the deflector in a closet in the Riverwalk A dining area. This deficient practice was verified by the Facilities Manager.	K 062	painting done in the future around sprinkler heads will be inspected by maintenance staff when painting projects are completed. This will be the responsibility of the Plant Operations Director	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 80 residents and an undetermined amount of staff and visitors.	K 144	The monthly generator log sheets were updated to document the cool down cycle on 6-23-16. This is the responsibility of the Plant Operations Director.	6/23/16

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K 144	Continued From page 5 Findings include: On the facility tour between 9:45 am to 2:30 pm on 06/08/2016 record review and staff interview revealed the generator cool down cycle was not being logged on the monthly reports. This deficient practice was verified by the Facilities Manager.	K 144		

MDH
Minnesota Department of Health

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00818	A. BUILDING: _____ B. WING _____	06/09/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/6 through 6/9/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan interventions were followed for 1 of 2 residents (R41) reviewed, who received an anticoagulant medication. Findings include: R41's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R41's diagnoses included congestive heart failure, atrial fibrillation (a-fib), irregular pulse, Alzheimer disease/ dementia, with moderate cognitive impairment and daily use of an anticoagulant medication. R41's care plan dated active 2/4/15, included, Category: Anticoagulant Therapy Alert. Problem: Coumadin for atrial fibrillation. Approach: Monitor for s/s (signs and symptoms) of bleeding. The identified s/s of bleeding included bruising. On 6/6/16, at 7:30 p.m. R41 was observed to	2 565	Corrected	7/18/16

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2 565	Continued From page 3	2 565		

have a dark purple to black oblong bruise on the back of the right hand. The bruise extended diagonally from R41's index finger knuckle to just above the wrist. The bruise remained the same during observations on 6/7/16, 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.

On 6/9/16, at 1:51 p.m. LPN-A identified R41 had

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2 565	Continued From page 4 a laboratory blood draw on the prior Wednesday and Friday from the back of the right hand. LPN-A indicated the bruise on the back of R41's hand may have come from these procedures; however verified no documentation of the bruise was found. On 6/9/16, at 1:54 p.m. RN-B indicated the bruise on R41's hand would have been from the lab draw. RN-B stated,"We do not do any skin and wound monitoring for that." RN-B verified when the source of bruising is from a lab draw the area would be looked at a second time when removing the band-aid, with no further documentation or monitoring. On 6/9/16, at 2:44 p.m. the director of nursing (DON) verified the expectation of all resident bruises to be reviewed and monitored with documentation in the record regardless if the cause was known. The DON stated further that residents receiving Coumadin should be more closely monitored because it was a high risk drug because of bleeding. The DON verified a higher PT/INR reading indicated it was out of the therapeutic goal and would expect R41 to be monitored for signs and symptoms of bleeding. The facility policy titled Resident MDS 3.0 Assessment and care plan reviewed 4/15 identified the objective as follows: To assess resident needs, design interventions based on assessment data and evaluate interventions outcomes on a scheduled and as needed basis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans. The DON could educate all appropriate staff on these	2 565		

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2 565	Continued From page 5 systems. The DON or designee could complete random audits to ensure ongoing compliance and report these results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bruising was assessed, monitored, and interventions implemented to prevent further bruising for 1 of 3 residents (R41) reviewed for non-pressure related skin conditions. Findings include: R41's quarterly Minimum Data Set (MDS) dated 3/18/16, identified R41's diagnoses included	2 830	Corrected	7/18/16

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2 830	Continued From page 6 congestive heart failure, atrial fibrillation (a-fib), irregular pulse, Alzheimer disease/ dementia, with moderate cognitive impairment and daily use of an anticoagulant medication. The physicians orders dated 6/10/16, identified Coumadin orders of 2.5 milligrams (mg) daily Sunday, Tuesday, Wednesday, Thursday, Friday and Saturday, 1.25 mg Monday. R41's care plan dated active 2/4/15, included, Category: Anticoagulant Therapy Alert. Problem: Coumadin for atrial fibrillation. Approach: Monitor for s/s (signs and symptoms) of bleeding. The identified s/s of bleeding included bruising. On 6/6/16, at 7:30 p.m. R41 was observed to have a dark purple to black oblong bruise on the back of the right hand. The bruise extended diagonally from R41's index finger knuckle to just above the wrist. The bruise remained the same during observations on 6/7/16, 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	2 830		

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	00818	A. BUILDING: _____ B. WING _____	06/09/2016

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2 830	Continued From page 7 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 indicated skin conditions including bruising would be measured and documented with size and color in the skin and wound book. The bruise would be added to the short term care plan, the details would be faxed to the primary physician, the family would be notified and the bruise would be followed and documented on each bath day until resolved. 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 identified all residents were to have skin reviewed once a week on bath day and any reported skin issues reviewed by the nurse. RN-B verified no documentation of R41's bruising was found. On 6/9/16, at 1:51 p.m. LPN-A identified R41 had a laboratory blood draw on the prior Wednesday and Friday from the back of the right hand. LPN-A indicated the bruise on the back of R41's hand may have come from these procedures; however verified no documentation of the bruise was found. On 6/9/16, at 1:54 p.m. RN-B verified the PT/INR (blood clotting lab test) for Coumadin use dated 6/1/16, was 2.95, which was longer than R41's therapeutic goal of 2.3. RN-B indicated the bruise on R41's hand would have been from this lab draw. RN-B stated,"We do not do any skin and	2 830		

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2 830	Continued From page 8 wound monitoring for that." RN-B verified when the source of bruising is from a lab draw the area would be looked at a second time when removing the band-aid, with no further documentation or monitoring. On 6/9/16, at 2:44 p.m. the director of nursing (DON) verified the expectation of all resident bruises to be reviewed and monitored with documentation in the record regardless if the cause was known. The DON stated further that residents receiving Coumadin should be more closely monitored because it was a high risk drug because of bleeding. The DON verified a higher PT/INR reading indicated it was out of the therapeutic goal and would expect R41 to be monitored for signs and symptoms of bleeding. The facility policy titled Skin Care Guidelines, revised 10/10, included the objective: "St. Francis Nursing Home will have a process in place to ensure that all skin conditions are reported, assessed, documented, and evaluated in a timely manner." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to non-pressure related skin issues such as bruising with anti-coagulant use. The DON could educate all appropriate staff on these systems. The DON or designee could complete random audits to ensure ongoing compliance and report these results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21805	Continued From page 9	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a dignified manner for 1 of 3 residents (R10) who utilized a transfer belt. Finding include: R10's annual Minimum Data Set (MDS) dated 3/4/16, identified R10 had diagnoses which included: diabetes, Parkinson's, and dementia. The MDS identified R10 had moderate cognitive impairment and required extensive assistance of one staff for bed mobility and transfers. The MDS also indicated R10 needed limited assistance of one staff to walk in her room, supervision of staff to walk in corridor and on and off the unit. R10's current care plan dated 11/5/11, indicated R10 had a self care deficit of activities of daily living (ADL's) related to weakness, confusion, lack of follow through and Parkinson's. The care plan indicated R10 walked independently with the use of a front wheeled walker (FWW), needed frequent cueing or would become lost, forgetting her walker, which required staff to retrieve. The care plan also indicated R10 would self transfer needing staff assistance with transfers to get in and out of chairs and utilized a transfer belt to	21805	Corrected	7/18/16

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21805	Continued From page 10	21805		

ease with transfers when up.

On 6/6/16, at 4:55 p.m. R10 was seated in the dining room eating her supper meal independently with several other residents seated at tables around her eating. R10 had a transfer belt fastened around her waist area. At 6:01 p.m. R10 remained seated at the dining room table and continued to have the transfer belt fastened around her waist area with several other residents seated in the dining room area. Nursing assistant (NA)-C walked up to R10, and assisted her to stand using the transfer belt fastened around her waist. R10 proceeded to walk alone, back to her room using her FWW. From 6:55 p.m. through the end of observation at 7:43 p.m. R10 was seated in her recliner in her room, with the transfer belt still fastened around the waist.

On 6/7/16, at 2:54 p.m. R10 was seated in her recliner in her room with the transfer belt fastened around her waist. At 3:24 p.m. R10 was in her room walking independently with her FWW and the transfer belt fastened around her waist. At 3:47 p.m. R10 stood next to her table in her room reading a magazine with the transfer belt fastened around her waist.

On 6/8/16, at 7:33 a.m. during observation of personal cares, NA-D placed a transfer belt around R10's waist. R10 then walked independently, down the hallway using her FWW. At 8:01 a.m. R10 was observed ambulating independently back to her room using her FWW. The transfer belt was fastened up under her breast/rib cage area. At 8:15 a.m. with the transfer belt remaining fastened under R10's breast/rib cage area, Licensed practical nurse (LPN)-C assisted R10 to stand from her recliner. R10 walked independently with her FWW to the

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dining room. R10 was given verbal cues from LPN-C to sit down in her chair.
At 8:30 a.m. R10 continued have the transfer belt fastened under her breast/rib cage area at the dining room table. Several other residents were in the dining room. At 10:00 a.m. R10 was seated in her recliner and continued to have the transfer belt fastened up under her breast/rib cage area. At 11:30 a.m. R10 was walking around her room independently with her FWW with the transfer belt fastened under her breast/rib cage area. At 1:00 p.m. R10 was seated in her recliner looking at a magazine with the transfer belt fastened under her breast/rib cage area. At 2:45 p.m. R10 remained in her recliner with the transfer belt on.

On 6/7/16, at 2:56 p.m. R10 stated staff told her she had to wear the transfer belt all the time so she did not fall. R10 stated "they think this belt around my belly will keep me from falling." R10 said "I don't like it." R10 stated "Oh I get dressed up and then I have to put that belt on me and that spoils my whole day." R10 indicated she told staff she did not like the transfer belt around her waist all the time. Staff has not removed the belt, then tell her she wouldn't want to fall. R10 stated "I'd rather not have it on." R10 indicated she was able to walk independently with the FWW for ambulation.

On 6/9/16, at 1:35 p.m. nursing assistant (NA)-E confirmed R10 wore the transfer belt consistently all day, she was independent with ambulation using her FWW and stated "she will walk all over the place." NA-E indicated R10 needed staff assistance to get in and out of the chair and she felt R10 was not a fall risk. NA-E stated R10 had a transfer belt on because it was on the care plan, but didn't know why R10 had it on all the time. NA-E felt it was not dignified to have R10

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21805	Continued From page 12 wear her transfer belt all the time. NA-E stated "I would not want to wear one all the time." On 6/9/16 at 1:39 p.m. registered nurse (RN)-A confirmed R10 wore the transfer belt consistently all day and confirmed it was her current care plan. RN-A indicated R10 needed assistance to get in and out of chairs and with transfers first thing in the morning. RN-A also indicated R10 did transfer herself at times and that was why she wore the transfer belt all the time. RN-A stated "its easier for us to get her up and down from the chairs." RN-A felt R10 was not a fall risk once she was up for the day, she was independent with ambulation using her FWW. RN-A indicted she was not aware that R10 did not want to wear the belt. RN-A indicted if R10 did not want the transfer belt around her, then it was not dignified for her to have it on. On 6/9/16, at 2:22 p.m. the director of nursing (DON) confirmed R10 wore the transfer belt consistently all day. The DON stated "we do use the transfer belt to help her up with transfers." The DON also stated "if it bothered a resident, I would never do it." The DON confirmed R10 was independent with ambulation in her room and on the unit. The DON also indicated it was not dignified to have the transfer belt riding up under R10's breast/rib cage area and stated "potentially that would be uncomfortable for the resident." Review of the undated, facility policy titled Patients/Clients/Residents Rights and Responsibilities, indicated under Dignity: "the facility must with courtesy promote and care for you in a manner and environment that maintains and enhances your dignity and respect in full recognition of your individuality".	21805		

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21805	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to the dignified care of residents such as the use of transfer belts. The DON could educate all staff on these systems. The DON or designee could complete random audits to ensure ongoing compliance and report these results to the quality assurance group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		