DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 12, 2022

Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, MN 56520

RE: CCN: 245265
Cycle Start Date: May 10, 2022

Dear Administrator:

On July 1, 2022, the Minnesota Department(s) of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 14, 2022

Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, MN 56520

RE: CCN: 245265
Cycle Start Date: May 10, 2022

Dear Administrator:

On May 10, 2022, a 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

If substantial compliance with the regulations is not verified by August 10, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by November 10, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 _____	C 05/10/2022

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 On 5/9/22, to 5/10/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52651109C, (MN00083161), H5265048C (MN00082830), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited. H5265047C (MN00082837), with deficiencies cited at (F609, F610). The following complaint was found to be UNSUBSTANTIATED: H5265049C (MN00081455). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		6/24/22

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

Electronically Signed | 06/24/2022

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 _____ B. WING _____	C 05/10/2022

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 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were immediately reported to the State Agency (SA), no later than 2 hours after knowledge of the allegation when the event that caused the allegation involved abuse, for 2 of 2 residents (R2, R5) reviewed for allegations of potential abuse.	F 609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Protect all residents by educating LTC staff on St. Francis Vulnerable Adult policy and Federal statute 483.12 Freedom from abuse, neglect and exploitation.	

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 _____	C 05/10/2022

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 609	Continued From page 2 Findings Include: R2's admission Minimum Data Set (MDS) dated 3/25/22, identified R2 was cognitively intact and had diagnoses which included: cancer, heart failure and end stage renal disease. R2's MDS indicated R2 required extensive assistance with transfers, toileting, personal hygiene and physical help with bathing from two staff. R2's care plan revised 4/20/22, identified R2 had a self-care deficit related to generalized weakness and deconditioning due to recent illness and cancer diagnosis. R2's care plan interventions included assistance of two staff with all personal hygiene and bathing assistance. R2's care plan identified R2 was vulnerable to abuse due to various diagnoses listed. Review of R2's SA report submitted 4/19/22, at 12:11 p.m. identified the allegation of abuse had occurred 4/19/22, at 10:15 a.m. The description of the allegation identified at 8:45 a.m., nursing assistant (NA)-A and NA-B had reported R2 refused her bath and NA-A stated R2 had reported she had tried to drown her last week. At 10:15 a.m. R2 informed the nurse on duty she did not feel safe and believed NA-A would harm her. The facility SA report identified the allegation of physical abuse occurred on 4/19/22, at 8:45 a.m. The SA report was submitted by the facility on 4/19/22, at 12:11 p.m., three hours and 26 minutes after the allegation was made. On 5/10/22, at 10:13 a.m. NA-A indicated R2 expressed a concern on 4/19/22, about the bath she had received the week before. NA-A stated	F 609	Emphasis was made on immediate reporting, no later than 2 hours. How the facility will identify other residents having the potential to be affected by the same deficient practice: Neighborhood communication books reviewed for 2022. No other incidents noted that would have qualified as a potential for abuse, neglect, and exploitation incident that needed to be filed as a VA report. 24 hour Charge sheets reviewed for 2022. No other incidents were identified as being potential for abuse, neglect, and exploitation incidents that would qualify as needed to be reported as a VA report. A & I reports reviewed for 2022, no other incidents noted that would have qualified as a potential for abuse, neglect, and exploitation incident that needed to be filed as a VA report. Social worker inquires with each resident during each MDS assessment and care conference about any concerns they may have while living in the facility. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: St. Francis Vulnerable Adult policy and Federal statute 483.12 Freedom from abuse, neglect and exploitation reviewed with all licensed staff, highlighting the reporting timeframe of potential abuse reporting. Licensed staff signed that they understand that all reports of potential abuse, neglect and exploitation must be reported to the state agency within 2	

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 _____	C 05/10/2022

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 609	Continued From page 3 when staff attempted to prepare R2 for her bath, she refused the bath and informed NA-A she had tried to drown her during her bath the week before. NA-A indicated she had reported the allegation to registered nurse clinical manager (CM)-A within 15 to 20 minutes after R2 made the allegation. NA-A stated CM-A and the facility licensed social worker (LSW)-A spoke to R2 and NA-A was sent home. On 5/10/22, at 10:27 a.m. R2 indicated staff treated her with respect and dignity for the most part however R2 identified she had one incident awhile back which occurred during her bath. R2 stated the staff member who provided the bath was very rude to her. On 5/10/22, at 10:56 a.m. registered nurse (RN)-A confirmed R2 was able to make her needs known. RN-A stated two staff were used to perform R2's cares, because she thought some false accusations had been made at one time. On 5/10/22, at 12:58 p.m. CM-A confirmed NA-A and NA-B had informed her R2 had made an allegation NA-A had attempted to drown her during her bath the week before. CM-A confirmed she had reported the allegation late to the administrator and to the SA as she was busy and believed R2 needed some time before CM-A interviewed her. CM-A stated the usual process of reporting an allegation of abuse was to contact the administrator right away, file a report to the SA, complete an incident report and remove the staff from the schedule they had been identified as an alleged perpetrator. CM-A indicated R2 had episodes of confusion and had made allegations in the past which were	F 609	hours. Additional training will be conducted with staff on the St. Francis Vulnerable Adult policy during the upcoming Annual Skills Training on July 18th thru 20th. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Neighborhood communication books and 24 hour Charge sheets will be reviewed every shift ensuring all potential incidents of abuse, neglect and exploitation have been reported per Code of Federal Regulations Statute and facility Vulnerable Adult policy. All Vulnerable Adult reports will be audited for timeliness of submission per policy and Federal Statute. Results of audits will be reported to the LTC QAPI committee. Monitoring will continue until at least 3 consecutive quarters of compliance have been achieved.	

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 _____	C 05/10/2022

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 609	Continued From page 4 unsubstantiated. R5 R5's quarterly MDS dated 4/26/22, identified R5 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, hypertension (high blood pressure), and cerebrovascular accident (stroke). R5's MDS identified she did not walk and required extensive assistance with transfers, toileting and personal hygiene. R5's MDS indicated she no delirium, behaviors or hallucinations. R5's care plan revised, 4/27/22, identified R5 had an activities of daily living (ADL) self-care performance deficit due to poor follow through/insight related to Alzheimer's disease and dementia. R5's care plan interventions included to identify what staff were going to do before starting cares and to offer reassurance throughout cares. R5's interventions instructed staff to enlist additional staff assistance when needed and R5 had perceived staff could be "rushed" or "rough" with cares at times. R5's interventions included assistance of one staff for personal hygiene, toilet use and transfers. R5's care plan identified R5 was vulnerable to abuse due to age, related cognitive decline and diagnoses. Review of R5's progress notes dated 1/1/22, to 5/10/22, identified the following: -1/18/22, at 9:27 a.m. certified nursing assistant (CNA) after CNA had R5 hooked up to the stand up lift while providing morning cares, she noticed R5's balance was not steady. CNA placed her hand to the back of R5's head for support and R5 stated "you slapped me". CNA apologized and	F 609		

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 _____	C 05/10/2022

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 609	Continued From page 5	F 609		

reassured R5 she had placed her hand behind her head for support. Family member was updated. CNA was able to complete cares without any further concerns expressed by R5.

Review of R5's Individual Grievance/Complaint Investigation Report form dated 1/18/22, instructed readers to refer to attached progress note from 1/18/22, at 9:27 a.m. R5's form identified licensed practical nurse (LPN)-A stated NA-C informed her R5 alleged NA-C had hurt her and NA-C denied the allegation. LPN-A notified R5's family member who had expressed no concerns. CM-B was aware of the situation and assessed R5's back of her head on 1/18/22, at 10:42 a.m. and no injury was observed.

The facility lacked documentation the administrator had been notified about the allegation and the allegation had been reported to the SA.

On 5/10/22, at 9:33 a.m. NA-C indicated she had been assisting R5 with cares by herself when R5 made the allegation of abuse. NA-C stated she informed R5 she had not hit her, completed R5's cares and assisted her out of her room. NA-C indicated she reported the allegation to LPN-A right away.

On 5/10/22, at 9:53 a.m. during a telephone interview LPN-A confirmed NA-C had informed her R5 stated she hit her. LPN-A indicated she had informed the charge nurse CM-B immediately. LPN-A stated she believed the allegation was not accurate however the facility should have reported it.

On 5/10/22, at 1:15 p.m. CM-B indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. BUILDING _____ B. WING _____	C 05/10/2022

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 609	Continued From page 6 usual process for handling allegations of abuse included reporting to the administrator right away, the director, family, resident and communicating to the IDT team. CM-B reviewed the grievance form and confirmed R5 reported NA-C had slapped her. CM-B indicated LPN-A had assessed R5 right away, determined no harm had been done and reported the allegation to the licensed social worker. During a follow-up interview on 5/10/22, at 2:43 p.m. CM-B confirmed R5's statement which alleged she had been hit by NA-C was an allegation of abuse. CM-B confirmed the allegation of abuse had not been reported to the administrator or reported to the SA due to the timing of it. CM-B explained she believed since the allegation had been reported to her right away, she was able to speak to LPN-A and NA-C right away and had checked R5 immediately for injury and as a result, she had not reported it. On 5/10/22, at 2:26 p.m. director of nursing (DON) stated when R5 had made allegations staff were expected to take them seriously however indicated R5 had delusions. DON confirmed R5 had not made false accusations in the past of staff hitting or slapping her. DON stated LPN-A and CM-B had assessed and interviewed R5 after the allegation had been made. DON confirmed R5's report of being slapped by staff was an allegation of abuse and would have expected staff to file a VA report if R5 had a red mark or repeated the allegation when interviewed. DON stated she believed filing a grievance form was appropriate in this situation in place of reporting the allegation to the SA since the facility still had a paper trail and had spoken to the family directly. DON confirmed the facility had not reported the	F 609		

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 _____	C 05/10/2022

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 609	Continued From page 7 allegation of abuse to the SA. On 5/10/22, at 1:34 p.m. administrator stated he expected staff to report allegations of abuse to the SA and to him. Administrator confirmed he had not been notified of the allegation of abuse made by R5 and verified the report had not been made to the SA. The facility policy titled Vulnerable Adult Abuse And Neglect Reporting dated 7/6/21, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish. The facility attached Appendix B-Long Term Care (Nursing Home), undated identified if a situation of suspected maltreatment of a resident arose, the licensed individual who was made aware of the situation was responsible for reporting the concern immediately. If the information gathered indicated a vulnerable adult report may be necessary, the Administrator on-call was notified immediately by telephone. The report must be filed no later than two (2) hours after discovery of the incident including abuse. The appendix also identified if the initial information supported the need for a Vulnerable Adult report to be submitted to the Office Of Healthcare Facility Complaints (OHFC), then the reporter would file a report immediately but no later that 2 hours after the concern had been identified. The Administrator or the Administrative designee (Administrator on-call) was to be notified immediately prior to filing the OHFC report. The facility policy titled Patient/Resident/Client (Non-Hippa Privacy) Grievance, dated 5/12/21, identified when applicable, a vulnerable adult	F 609		

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 _____	C 05/10/2022

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 609	Continued From page 8 and/or elder justice report would be filed with the appropriate agency. The policy instructed to see Vulnerable Adult Reporting Policy and Procedure.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 1 of 2 residents (R5) reviewed for allegations of abuse. In addition, the facility failed to protect the resident and report to the State Agency (SA) the results of the investigation within 5 working days for 1 of 1 allegations of abuse reviewed. Findings Include: R5's quarterly MDS dated 4/26/22, identified R5	F 610	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Protect all residents by educating LTC staff on St. Francis Vulnerable Adult policy and Federal statute 483.12 Freedom from abuse, neglect and exploitation. Emphasis was made on completing a full investigation within 5 working days of the incident and reporting findings to the state agency.	6/24/22

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 _____	C 05/10/2022

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 610	Continued From page 9 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, hypertension (high blood pressure), and cerebrovascular accident (stroke). R5's MDS identified she did not walk and required extensive assistance with transfers, toileting and personal hygiene. R5's MDS identified she had no delirium, behaviors or hallucinations. R5's care plan revised, 4/27/22, identified R5 had an activities of daily living (ADL) self-care performance deficit due to poor follow through/insight related to Alzheimer's disease and dementia. R5's care plan interventions included to identify what staff were going to do before starting cares and to offer reassurance throughout cares. R5's interventions instructed staff to enlist additional staff assistance when needed, and R5 had perceived staff could be "rushed" or "rough" with cares at times. R5's interventions included assistance of one staff for personal hygiene, toilet use and transfer. Review of R5's progress notes dated 1/1/22, to 5/10/22, identified the following: -1/18/22, at 9:27 a.m. certified nursing assistant (CNA) went to do cares that morning and when CNA had R5 hooked up to the stand up lift, she noticed her balance was not steady. CNA placed her hand to the back of R5's head for support and R5 stated "you slapped me". CNA apologized and reassured R5 she had placed her hand behind her head for support. Family member was updated. CNA was able to complete cares without any further concerns expressed from R5. Review of R5's Individual Grievance/Complaint Investigation Report form dated 1/18/22, instructed readers to refer to attached progress	F 610	How the facility will identify other residents having the potential to be affected by the same deficient practice: Neighborhood communication books reviewed for 2022. No other incidents noted that would have qualified as a potential for abuse, neglect, and exploitation incident that needed to be filed as a VA report. 24 hour Charge sheets reviewed for 2022. No other incidents were identified as being potential for abuse, neglect, and exploitation incidents that would qualify as needed to be reported as a VA report. A & I reports reviewed for 2022, no other incidents noted that would have qualified as a potential for abuse, neglect, and exploitation incident that needed to be filed as a VA report. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: St. Francis Vulnerable Adult policy and Federal statute 483.12 Freedom from abuse, neglect and exploitation reviewed with all licensed staff, highlighting the portions which pertain to protecting all residents by thoroughly investigating allegations and reporting the investigation results to the state agency within 5 working days. Licensed staff signed that they understand that all reports of potential abuse, neglect and exploitation must be thoroughly investigated to protect all residents and report the investigation findings to the state agency within 5 working days.	

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 _____	C 05/10/2022

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 610	Continued From page 10 note from 1/18/22, at 9:27 a.m. R5's form identified licensed practical nurse (LPN)-A stated nursing assistant (NA)-C informed her R5 alleged NA-C had hurt her and NA-C denied the allegation. (LPN)-A notified R5's family member who had expressed no concerns. Registered nurse case manager (CM)-B was aware of the situation and assessed R5's back of her head on 1/18/22, at 10:42 a.m. and no injury was noted. The grievance form identified NA-C, LPN-A and R5 were interviewed. The facility's documentation lacked information to support a thorough investigation had been completed such as: protection of the resident by removing the alleged perpetrator from the facility during the investigation, completing further resident and staff interviews to ensure no other allegations existed and had not completed a 5 day investigation report to the SA. On 5/10/22, at 9:33 a.m. NA-C indicated she had been assisting R5 with cares by herself when R5 made the allegation of abuse. NA-C stated she informed R5 she had not hit her, completed R5's cares and assisted her out of her room. NA-C indicated she reported the allegation to LPN-A right away. NA-C stated she was not aware of what had been done with the allegation once it had been reported. On 5/10/22, at 9:53 a.m. during a telephone interview LPN-A confirmed NA-C had informed her R5 reported she hit her. LPN-A indicated she had informed the charge nurse CM-B immediately. LPN-A stated she believed the allegation was not accurate however the facility should have investigated it to see determine if it was true. LPN-A stated she had interviewed R5	F 610	Additional training will be conducted with staff on the St. Francis Vulnerable Adult policy during the upcoming Annual Skills Training on July 18th thru 20th. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Neighborhood communication books and 24 hour Charge sheets will be reviewed every shift ensuring all potential incidents of abuse, neglect and exploitation have been reported per Code of Federal Regulations Statute and facility Vulnerable Adult policy. All Vulnerable Adult reports will be audited ensuring a full investigation has taken place within 5 working days of the incident. Results of audits will be reported to the LTC QAPI committee. Monitoring will continue until at least 3 consecutive quarters of compliance have been achieved.	

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 _____	C 05/10/2022

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 610	Continued From page 11 after the allegation had been made however she could not recall what R5 had said. On 5/10/22, at 1:15 p.m. CM-B reviewed the grievance form and confirmed R5 reported NA-C had slapped her. CM-B indicated LPN-A had assessed R5 right away, determined no harm had been done and CM-B reported the allegation to the licensed social worker. During a follow-up interview on 5/10/22, at 2:43 p.m. CM-B confirmed R5's statement which alleged she had been hit by NA-C was an allegation of abuse. CM-B explained she had checked R5 for injury after the allegation had been made and interviewed NA-C and LPN-A. CM-B confirmed a thorough investigation had not been completed due to the timing of the assessment of R5 and timely interviews of the two staff involved. On 5/10/22, at 2:26 p.m. director of nursing (DON) stated when R5 had made allegations of abuse staff were expected to take them seriously however indicated R5 had delusions. DON confirmed R5 had not made false accusations in the past of staff hitting or slapping her. DON stated LPN-A and CM-B had assessed and interviewed R5 after the allegation had been made. DON confirmed R5's report of being slapped by staff was an allegation of abuse. DON stated the staff handled the and would have expected staff to file a VA report if R5 had a red mark or repeated the allegation when interviewed. DON stated she believed filing a grievance form was appropriate in this situation in place of reporting the allegation to the SA since the facility still had a paper trail and had spoken to the family directly. DON confirmed the facility	F 610		

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 _____	C 05/10/2022

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 610	Continued From page 12 had not reported the allegation of abuse to the SA. On 5/10/22, at 1:34 p.m. administrator stated he expected staff to report allegations of abuse to the SA and to him. Administrator confirmed he had not been notified of the allegation of abuse made by R5 and verified the report had not been made to the SA. On 5/10/22, at 2:26 p.m. director of nursing (DON) confirmed R5's statement "you hit me" was an allegation of abuse. DON stated LPN-A and CM-B had assessed and interviewed R5 and R5 had not repeated the allegation. DON indicated since R5 never made the statement again, she believed the staff handled the allegation appropriately. On 5/10/22, at 3:05 p.m. during exit interview, administrator confirmed the facility had not thoroughly investigated R5's allegation of abuse. The facility policy titled Vulnerable Adult Abuse And Neglect Reporting dated 7/6/21, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish. The facility attached Appendix B-Long Term Care (Nursing Home), undated identified an investigation included the charge nurse or DON would conduct a physical examination of any alleged victim(s) immediately. The appendix also identified the investigation may include interviewing all persons associated with the situation, residents who had the potential to have had similar situations, medical records and physical assessment. The appendix further identified if the vulnerable adult report involved an	F 610		

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 _____	C 05/10/2022

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 610	Continued From page 13 employee, the investigation team would determine the corrective action regarding the employee and to prevent further potential abuse while the investigation was in process, staff may be placed on suspension or probation during the investigation and the outcome of the investigation would determine retention of termination of the involved staff.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 14, 2022

Administrator
St Francis Home
2400 St Francis Drive
Breckenridge, MN 56520

Re: Event ID: BKFS11

Dear Administrator:

The above facility survey was completed on May 10, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 _____	C 05/10/2022

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/9/22, to 5/10/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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 _____	C 05/10/2022

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) COMPLETE DATE
2 000	Continued From page 1 SUBSTANTIATED: H52651109C, (MN00083161), H5265048C (MN00082830) however NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5265047C (MN00082837), H5265049C (MN00081455). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		