



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 2, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

RE: CCN: 245265

Cycle Start Date: March 17, 2026

Dear Administrator:

On May 5, 2026, the Minnesota Department 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

Re: Reinspection Results
Event ID: 1F386D-H2

Dear Administrator:

On May 5, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 17, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

RE: CCN:245265

Cycle Start Date: March 17, 2026

Dear Administrator:

On March 17, 2026, a survey was completed at your facility by the Minnesota Department of Health 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 June 17, 2026 (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 September 17, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

Administrator
ST FRANCIS HOME
2400 ST FRANCIS DRIVE
BRECKENRIDGE, MN 56520

Re: State Nursing Home Licensing Orders

Event ID: 1F386D-H1

Dear Administrator:

The above facility survey was completed on March 17, 2026 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0000	INITIAL COMMENTS On 3/12/26, 3/16/26, and 3/17/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H52657740C (2793268) with a deficiency issued at F689. As a result of the compliant investigation, a deficiency was issued at F684. 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.		F0000			04/10/2026	
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review, the facility failed to provide a comprehensive assessment by therapy for 1 of 3 residents (R3) to		F0684	Acknowledgement of Deficiency F0684 The facility failed to ensure a physical therapy evaluation was completed prior to implementing a stand lift, resulting in care not being provided in accordance with professional standards of practice for safe transfers. 2. Immediate Corrective Action (Resident-Specific) A comprehensive PT assessment was conducted, including: Transfer ability and level of assistance Weight-bearing status		05/01/2026	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0684 SS = D	Continued from page 1 ensure the resident received treatment and care in accordance with professional standards of practice. Findings include: R3's significant change Minimum Data Set (MDS) dated 12/23/25, identified R3 had severely impaired cognition with disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject), and no behaviors. R3 had limited range of motion/impairment upper extremity on one side. R3 required substantial/maximal assistance with toileting hygiene, lower body dressing, sit to stand, all transfers, partial/moderate assistance with personal hygiene, and used a motorized wheelchair/scooter for mobility. R3 diagnoses included non-traumatic brain dysfunction, heart failure, arthritis, Alzheimer's Disease, dementia, depression, psychotic disorder, Parkinson (neurological disorders causing movement problems, including slowness, rigidity, tremor, and balance issues). R3 had no falls since entry and re-entry to the facility. Height was 70 inches (5 feet 8 inches) and weight was 228 pounds. R3 was not receiving therapy (physical, occupational, restorative). R3's fall risk assessment dated 12/9/25, identified no falls in the last 90 days. Cognition status had changed in the past 90 days. R3 was easily distracted with periods of altered perception or awareness of surroundings. Episodes of disorganized speech, restlessness, and periods of lethargy. Mental function varied over the course of the day. Balance was unstable and was only able to stabilize with human assistance. R3's fall risk score was 20 (high risk 16-20). R3's care plan revised last on 3/17/26, identified he was at risk for falls related to festinating gait/balance (described as feeling like stuck in place, when initiating a step or turning) problems secondary to Parkinson's disease, psychoactive drug use, vision/hearing problems. R3 had a self-care deficit with increasing motor difficulty, chronic disease and decreased activity intolerance. Interventions included: -Date initiated 12/27/18, resolved 12/18/25, toilet use: required extensive assist of one. Often takes himself. Will call if incontinent episode. -Date initiated 12/18/25, and resolved: 2/4/26, transfer assist of two with bariatric SUL (stand up lift) (type of lift designed to assist individuals with limited mobility in transitioning from a seated to a		F0684	Continued from page 1 Strength, balance, and cognition Safety with assistive devices Based on PT evaluation: The appropriate transfer method was determined (e.g., stand lift, mechanical lift, or alternate assist) The care plan and Kardex were updated to reflect the correct transfer status Nursing staff received immediate re-education and return demonstration on proper transfer technique for this resident The attending provider was notified of the updated transfer status Therapy referrals have been sent for all like residents to identify appropriate standards of practice for safe transfers. Care plans and Kardex's will be updated upon completion of therapy evaluation. 3. Systemic Corrective Actions System Changes Implemented: The facility has implemented the Bedside Mobility Tool (BMAT) for nurses. Nursing staff has been educated and oriented to BMAT BMAT has been added to the Fall Huddle BMAT will be documented for a resident change in condition that is impacting mobility Revised transfer assessment protocol to require:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0684 SS = D	Continued from page 2 standing position safely. Bariatric models are specially engineered to accommodate higher weight capacities, ensure safety, and comfort for larger patients). Sling size XL. Tendency to self-transfer. -Date initiated 2/3/26, fall on 2/1/26, with assisted transfer. No injury. Assist of two for transfer safety. OT referral. -Date initiated 2/4/26 (current), transfer assist of two with Medline SUL. Sling evaluation monthly. -Date initiated 3/5/26 (current), Fall on 2/21/26, with assisted transfer. No injury. Therapy referral. Recommendations: SUL (non-bariatric) assist of two Extra large (XL) sling on red loops. Leg and check straps donned and tightened. Sign posted in room. PT for strengthening. R3 had a self care deficit. Resident care sheet dated 3/5/26, identified R3 was a fall risk and transferred with a regular SUL assist of two and an XL sling. A staff communication report calendar dated 2/2/26 through 2/8/26, identified R3 required assist of two sit-to-stand with bariatric lift (SUL). Follow-up charting. Ensure sling straps were secure with all transfers. On 2/24/26, occupational therapy (OT) evaluation: change to Medline SUL assist of two (frame was different than the other bariatric SUL) less slack in the sling. Interdisciplinary teams (IDT) meeting notes for R3 identified: -On 12/23/26, clarification, R3 bariatric SUL due to illness and stature. -On 2/3/26, fall during transfer with standing lift. No apparent injury. Lift evaluation on weekend (W/E) by maintenance. Re-evaluation by biomed. OT referral on transfer safety. -On 2/24/26, weakness, fall from Medline SUL recent evaluation after last occurrence. Therapy evaluation. Full body lift (FBL) until evaluation. Await therapy recommendations (RECC). Staff education document undated, identified Lift Safety: take seriously can cause injury to resident and/or staff. Ensure proper lift for resident. Legs should be at widest when turning, go slow, and take		F0684	Continued from page 2 PT evaluation and/or BMAT assessment prior to any new mechanical or stand lift use PT reassessment with any fall or change in condition involving mobility Added transfer status verification to: Admission process Post-fall review Change in condition workflow Implemented a Transfer Equipment Tracking Log to ensure: All residents using stand lifts have a current PT evaluation on file Added therapy participation to daily IDT/clinical meetings to review: New transfer needs Equipment changes Education and competency validation completed for all nursing staff on: Proper use of stand lifts Requirement for PT evaluation prior to use Risks of inappropriate lift use Therapy staff were educated on the updated process for the corrective action plan.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0684 SS = D	Continued from page 3 your time. Lock brakes when hooking up and disconnecting slings, unlock brakes when operating lifts. Once you start lifting with the machine, as the straps are about to get tight, check again to ensure everything is in the correct place. R3's progress notes dated from 12/1/25, through 2/26/26, identified: -On 12/1/26 at 4:37 a.m., R3 required assist of two with SUL for all transfers. He had been able to call for help and express needs. R3 was extremely shaky while he tried to hold onto the SUL and sometimes had hard time properly aligning his legs on the SUL. Reassurance was provided. -On 12/1/25 at 1:25 p.m., with increased tremors, slurred speech, increased hallucinations referred to emergency room (ER) for evaluation. -On 12/1/25 at 2:40 p.m., returned from ER. Elevated kidney functions. FU with primary provider. -On 12/1/25 at 7:20 p.m., R3's upper and lower extremity involuntarily shaking/twitching intermittently. R3 voiced frustration with having to call for help as compared to four days ago when he could go the bathroom by himself. Educated resident for his safety to continue to call for help with transfers and toileting due to unsteadiness caused by shaking/twitching. Words continued to be somewhat garbled and difficult to understand the meaning of what he said. -On 12/4/25 at 5:26 p.m., R3 was sent back to ER at 11:50 a.m. for acute kidney failure. At 5:00 p.m. returned to facility. -On 12/9/25 at 1:54 p.m., urinary tract infection (diagnosed on 12/6/26) currently on antibiotic. R3 back to baseline with strength, stands well with the SUL with assist. Tremors have significantly improved as have the complaints of hallucinations. -On 12/11/25 at 2:48 p.m., not currently on restorative therapy. R3 utilized standard wheelchair and ant-roll brakes. -On 12/19/25 at 7:04 p.m., back to ER at 3:10 p.m. and diagnosed with Influenza A and dehydration. -On 1/1/26 at 9:59 a.m., R3 has had a significant decline in health recently.		F0684	Continued from page 3 4. Monitoring / Quality Assurance Plan The DON or designee will conduct audits: 5 residents weekly for 4 weeks, then 5 residents monthly for 2 months Audits will verify: Residents using stand lifts have a current PT evaluation Transfer methods match PT recommendations Care plans accurately reflect transfer status Findings will be reviewed by the Quality Assurance and Performance Improvement Committee Additional interventions will be implemented if compliance is not sustained. 5. Responsible Party The Director of Nursing will be responsible for all aspects of the plan of correction.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0684 SS = D	Continued from page 4 -On 1/1/26 at 11:40 p.m., staff encouraged R3 use of the bathroom due to increased need for assistance with toileting. -On 1/5/26 at 4:26 p.m., Continued to require staff assist of one with toileting, transfers and cares due to some weakness and shakiness. -On 2/1/26 at 3:03 p.m., R3 laid on floor with upper body resting on aide lap. Alert, oriented, and denies pain. Sling loop slid off the stand lift. Aide stated he did not hit head and slowly lowered to the floor. Vitals taken, assessment completed, and full body lift was used with assist of two aides and nurse to sit resident in recliner. No injuries noted upon inspection. -On 2/21/26 at 9:05 a.m., R3 was being transferred off the toilet using the Medline SUL, hooked on correctly, legs gave out could no longer hold himself up any longer. Lift was lowered down and was caught with his arms elevated. Took three staff members to assist him out of the lift. Full body lift obtained with a crisscross lift sheet and assisted off the ground to his recliner. R3 was unable to state what happened. Assessed no injury. -On 2/22/26 at 2:00 p.m., had assisted fall yesterday. No complaints of pain. Has been transferring well with lift. No injuries noted from fall. -On 2/25/26 at 1:19 p.m., R3 has had increased weakness and decline in mobility due to Parkinson's. Required assistance of two staff and SUL for transfers. -On 2/26/26 at 2:40 p.m., discussed with R3 and wife PT evaluation for effective, safe transfer technique. Sign posted in room with reminders about plan specifics. Therapy for strengthening had been initiated. Observed on 3/12/26, located on R3's bathroom door, an undated sign, PT EDUCAUTION: TRANSFER PROCUDURE. Use standing mechanical lift. Assist of X2. Extra large (XL) sling. Place on RED loops when attaching to the lift. Ensure leg strap and check strap are donned and tightened. Educate R3 to hold on to the lift handles at all times. Occupational therapy (OT) evaluation dated 2/4/26, R3 was referred to OT for evaluation for safe transfer/lift implementation. R3's left upper extremity (LUE) fine motor coordination was impaired/limited due to left shoulder pain. He had previously used the		F0684				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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
F0684 SS = D	Continued from page 5 standing lift and had an incident where the lift sling let go from the lift. OT observed R3 in the lift that was used during the incident. He did not use the knee blocks of lift due to limited range of motion (ROM) in bilateral knees and pain to support with standing. He was able to extend both knees withstanding as lift brought him up into a standing position. LUE required assistance to move hand to handle. It was noted that the potential for sling straps to be released without physical assist maybe possible when the bilateral upper extremities (BUE) were higher than the lift with this model. The hooks on the lift are approximately 1.0 centimeter (cm) apart. Therapist and rehab aide present R3 with the Medline Standing lift. This lift with the same lift sling was used to test transfer of the resident. The transfer was stopped in various positions to test the possibility of the strap releasing, each time the sling loops stayed intact, and space between lift hooks was less than ¼ of an inch. R3 and therapist reviewed safety strategies with the lift sling. R3 appeared to be comprehend, and all transfers appeared safe with this lift selection. Clinical impressions: R3 would benefit from a change to midline standing lift due to his height and size. Nursing staff had been notified of recommended change. Physical therapy (PT) evaluation and plan of treatment dated 2/24/26, identified referred for physical therapy secondary to increased difficulty with transfers with patient falling from mechanical lift. R3 had been able to transfer using the standing bariatric mechanical lift and nursing had changed him to a full lift since fall. R3's functional assessment identified left side weakness, left shoulder pain, deficits in proprioception (the ability to sense the orientation, position, and movement of your body), demonstrated fear of anterior weight shift during standing, deficits in standing tolerance and balance, and required total dependence upon staff for transfers. Physical therapy caregiver note dated 2/24/26, Transfers: patient able to transfer safely with standing mechanical lift (non-bariatric) with assist of two. Place sling size XL on red loops when attaching to lift. Ensure leg strap and chest strap are donned and tightened. R3's occupational therapy evaluation and plan of treatment dated 2/24/26, identified he presented with impaired balance, fine motor coordination, groom motor coordination (use of large muscle groups), dexterity, mobility and strength resulting in limitations and/or participation restrictions in the areas of self-care mobility, and general tasks and demands. R3			F0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0684 SS = D	Continued from page 6 demonstrated good tolerance to EZ stand lift, no overt signs of risk/decreased safety with mechanical sit-to-stand. He required cuing to not push back on EZ stand (brand of sit-to-stand) and noted decreased left shoulder function. During an interview on 3/1/7/26 at 10:20 a.m., registered nurse (RN)-A stated R3 had a change in condition and was unstable for months from December 2025 to February 2026, acute renal failure, Parkinson’s, congestive heart failure, and influenza A. He was unable to stand, nursing judgement was used, and decided the next step was to be moved to a stand up lift. RN-A stated IDT and herself made this decision to transfer R3 with a bariatric SUL (does not have a lower leg strap) without a therapy assessment. The facility did not have access to therapy (OT or PT) from end of 11/25 until 2/3/26. Therapy would have been expected to complete R3’s assessment but was not available. In an emergency, the nurse would have made the decision as to the next level the resident would have been moved to, and which lift to be used. Expectation would be for nursing to document the assessment in the progress notes. R3 transferred with the SUL without incident until the fall on 2/1/26, without injury. The care sheet was incorrect, indicated assist of one and should have been two, RN-A unsure how that was determined. A referral to therapy was made on 2/3/26, and R3 was switched to Medline SUL so there was less slack in the sling. R3 was not safe to transfer without hands on assist. During an interview on 3/17/26 at 12:30p.m., physical therapist (PT) and occupational therapist (OT) together. PT stated she had worked at this facility since 2/2/26, contracted through a physical therapy company. PT stated based on how much assistance a resident required with a transfer, a therapy evaluation would be needed to determine which lift would be appropriate and safe. R3 received an assessment from OT on 2/4/26. R3 was changed from the lift he had an incident on 2/1/26, to a midline standing lift due to his height and size. This type of lift would be safer: helped get him over the threshold of the doorways due to his weight of over 230 pounds, made sure he stood up correctly (had weak legs) and therefore would prevent falls and accidents. OT stated R3 required the use of the non-bariatric midline stand lift to be safe. This type of stand lift provided less space, a knee strap which he needed for a safe transfer and allowed him to stand upright better. During an interview on 3/17/26 at 5:20 p.m., administrator stated a therapy assessment should have		F0684				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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
F0684 SS = D	Continued from page 7 been completed on a resident prior to the use of the lift for the best interest of the resident, to prevent falls, as well as any type of injury to resident or staff. Therapy would have determined the best and safest route to transfer a resident by assessing ergonomics, size/weight, proper way to lift and transfer a resident from one place to another, not one size fits all. R3 should have been assessed by therapy when his condition changed. Therapy was not available on site at the nursing home however, we had the availability to get therapy (OT/PT) if needed and could have reached out to a sister facility. During an interview on 3/17/26 at 5:30 p.m., director of nursing (DON) stated therapy assessed resident limitations, multiple tool choices for the job and determined the best tool. Therapy (OT/PT) were educated and had the expertise on how to assess the safest way to transfer, whether the resident could bear weight, tolerate it, and take into consideration the body mass index especially when high. Facility policy Fall Prevention Program dated 1/2009, identified falls are not a normal occurrence for the elderly. Falls that do not cause injuries may lead to fear of falling, which in turn may cause the residents to be less active. The goal of this program is to reduce the resident's risk of falling by identifying the elements of deficit and related safety issues by the following methods: -Assessment of the health-related components of falls. -Assessments and modifications of the environmental factors related to falls. -Assessment of Fall risk. -Prevention and rehabilitation. Physical and occupational therapy fall prevention responsibilities included: Assessments of activities of daily living (ADL), balance/endurance and assistive devices /abilities.			F0684			
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free			F0689	1. Acknowledgement of Deficiency #0689 The facility acknowledges the cited deficiency regarding failure to follow the manufacturer's instructions during a transfer using a stand lift, which has the potential to impact resident safety. 2. Immediate Corrective Action		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0689 SS = D	Continued from page 8 of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record, and manufacturer's instruction review the facility failed to follow manufacturer's instruction for 1 of 3 (R4) residents during a transfer with a stand lift. Findings include: R4's quarterly Minimum Data Set (MDS) dated 2/4/26, identified R4 had intact cognition and no behaviors. R4 required substantial/maximum assistance with shower/bathing, upper body dressing, personal hygiene, sit to stand, all transfers, dependent for toileting hygiene and lower body dressing, unable to walk and used a wheelchair for mobility. R4 was occasionally incontinent of bladder and always continent of bowel. R4's diagnoses included debility, cardiovascular conditions, hemiplegia/hemiparesis (weakness or paralysis on one side of the body), muscle spasms, osteoarthritis (protective cartilage that cushions the ends of the bones wears down over time), anxiety, height 62 inches (5 feet 1 inch), weight 238 pounds, body mass index (amount of body fat based on height and weight) 45.0 - 49.9 (over 40 was identified as morbid obesity). She was not receiving therapy (physical, occupational, restorative). No falls since admission. R4's care plan last updated on 1/29/26, identified high risk for falls related to obesity, osteopenia (reduction of bone density), chair bound, past fall, and polypharmacy (several medications taken each day). R4's muscle spasms better managed due to back on routine medications. Staff were directed to stay near but do not need to stay in bathroom. R4 had difficulty with elimination with staff close. R4 had an activity of daily living (ADL) self-care deficit related to hemiplegia and limited range of motion. R4 was unable to walk, and staff were directed to transfers with assist of one and bariatric SUL (stand up lift) (type of lift designed to assist individuals with limited mobility in transitioning from a seated to a standing position safely. Bariatric models are specially engineered to accommodate higher weight capacities, ensure safety, and comfort for larger patients), and		F0689	Continued from page 8 The resident involved was assessed for injury immediately following the incident. Like resident care plans are being reviewed and updated to reflect the correct transfer method per manufacturer guidelines. Staff involved received immediate re-education prior to returning to independent transfers. 3. Systemic Corrective Actions To prevent recurrence, the facility has implemented the following systemic interventions: All licensed nurses, nursing assistants, and agency staff were re-educated on proper use of stand lifts according to manufacturer instructions. A competency validation process was completed for all staff performing transfers, including return demonstration. Manufacturer instructions for each stand lift model have been made readily accessible to staff The orientation process for new and agency staff has been revised to include hands-on training and competency verification for lift equipment prior to assignment. Policy is under review by nursing and therapies for appropriate information. 4. Monitoring / Quality Assurance Plan The Director of Nursing (DON) or designee will conduct audits of stand lift transfers to ensure ongoing compliance. Frequency:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0689 SS = D	Continued from page 9 assist with toileting and associated hygiene. Resident care sheet dated 3/5/26, identified R4 transferred with a bariatric SUL assist of one and assist of two as needed (PRN) and an XL sling. Additional instructions included, make sure lift legs are spread apart when transferring please. R4's fall risk assessment dated 1/21/26, identified R4 admitted to facility on 8/22/11, no falls, confined to a chair, required physical assistance to maintain balance while standing. Fall risk score 16 (high risk 16-20). R4's physical therapy (PT) evaluation dated 2/6/26, identified precautions: left hemiplegia, inability to use left hand to functionally hold onto lift, left knee extension lacking 40 degrees from full extension due to pain. She required total dependence with attempts to initiate transfers. R4 was unable to use left upper extremity (LUE) to hold handle for support during transfer but was able to maintain position safely in sling with arm stretched out laterally during transfers and able to use lower extremities to attain partial standing position to allow transfer from wheelchair to toilet. She will benefit from continued PT treatment and further assessment of transfers to ensure safety and recommendations as necessary. During an observation on 3/16/26 at 3:38 p.m., nursing assistant (NA)-A pushed a bariatric SUL into R4's room. R4 sat in her wheelchair. NA-A opened the legs of the lift machine and pushed it in front of the R4's wheelchair. NA-A placed a royal blue trimmed in black sling around R4 and secured the belt closed around R4's waistline. NA-A stood in front of wheelchair while R4 pulled the sling belt strap tight, and hooked red loops to the second metal loop on the lift. NA-A did not engage the lift's brakes. NA-A pushed the lift button, raised R4 out of the wheelchair. R4 held onto the hand grip with only the right hand. R4's left hand/arm was positioned horizontally straight out backwards from her body with thumb pointed down towards the floor. Her body was slightly slouched down, knees bent, butt pushed outwards from her body and appeared to hang from the lift. NA-A pulled the stand lift away from the wheelchair, moved the lever and brought the legs of the lift together, pushed the lift machine into the bathroom, and up to the toilet, pulled down R4's pants, and pushed the lift button to lower R4 onto the toilet. R4's feet remained on lift platform and hooked up to lift machine via leg sling. NA-A instructed R4 to turn on call light when finished. NA-A did not engage lift		F0689	Continued from page 9 Five (5) transfer observations weekly for 4 weeks Then monthly for 2 additional months, or until compliance is sustained Audit Elements: Proper sling application Correct positioning and use of equipment Adherence to manufacturer instructions Alignment with resident care plan Audit results will be reviewed quarterly through the facility's QAPI program. Any identified concerns will be addressed immediately with re-education and/or corrective action. 5. Responsible Party The Director of Nursing will be responsible for all aspects of the plan of correction.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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
F0689 SS = D	Continued from page 10 stand brakes prior to leaving the bathroom and closing the bathroom door. NA-A sanitized hands, exited R4's room and closed the door. Five minutes later, R4 placed call light on and NA-A entered her room. NA-A pushed the lift button to lift R4 off the toilet with the stand lift machine. NA-A did not open the legs of the machine, pulled R4 away from the toilet, completed peri cares with gloves on, and pulled up R4's pants. NA-A pushed pushed the lift out of the bathroom, opened the legs of the lift to clear the wheelchair, and pushed the lift button to lower R4 into her wheelchair. NA-A did not engage the lift's brakes prior to lowering R4 into her wheelchair. NA-A removed the sling loops from the SUL and the transfer belt from R4's waist. NA-A pulled the lift machine away from the wheelchair, placed legs of lift back together, adjusted R4's clothing, sanitized hands and removed the SUL out of R4's room. During the observation, NA-A did not ask R4 if she wanted the brakes on the lift machine and R4 did not ask for the brakes to be engaged. During an interview on 3/12/26 at 11:35 a.m., R4 sat in her room in a motorized wheelchair, well-groomed and stated she lived at facility for 14 years. She required assistance to the bathroom and used a stand lift to transfer. R4 felt some of the new staff lacked knowledge, did not seem to know what to do at times, and transferred her too fast with the stand lift. R4 stated she asked them to slow down many times as she did not want to risk her safety. During an interview on 3/16/26 at 4:45 p.m., NA-A stated she had received education on the SULs, the floor manager demonstrated them for staff. Staff were expected to use the brakes on the SUL before the resident was hooked up to the machine and to keep the brakes engaged while lifting the resident up. It was expected, the brakes were disengaged once staff were ready to move the lift. NA-A stated the brakes should have been engaged prior to lowering R4 onto the toilet, but R4 did not like the brakes engaged. NA-A stated R4 felt, "trapped in," when brakes were engaged. NA-A stated it would have been important to use brakes on the SUL as the resident weighs down the machine, the wheels could have moved the machine away from R4 and resulted in an injury or fall. NA-A stated she received education, was told to engage the SUL brakes but did not do that with R4. NA-A stated she previously informed R4 it was important to engage the brakes but R4 still insisted she did not want them on. NA-A stated she used the brakes with all other residents and most likely should have used them while R4 sat in bathroom alone, and remained hooked up to the SUL, in case her feet moved the machine and caused a fall.			F0689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0689 SS = D	Continued from page 11 During an interview on 3/17/26 at 10:20 a.m., registered nurse (RN)-A stated once staff positioned the SUL in front of the resident, they were expected to engage the brakes. The brakes would have helped lock the machine in place to avoid it from sliding side-to-side while the sling loops were being connected. The resident would be lifted off the chair, brakes disengaged and moved to the bathroom. Once resident was positioned in front of the toilet, RN-A expected the brakes were engaged before the resident was lowered onto toilet. If the resident remained connected to the lift machine via sling, RN-A expected the brakes remained engaged. This was important as resident movement could have caused the SUL to move away and may have resulted in an accident/fall. The staff were expected to remain in the room to help prevent an accident. When a resident refused brakes to be engaged on the SUL, RN-A expected staff to educate the resident, safety always overrode the resident's request. During an interview on 3/17/26 at 10:56 a.m., clinical engineering (CE) stated he completed the facility lift inspections annually and as needed. Staff would be expected to have applied the brakes on the SUL after they opened the legs of the machine to go around the chair/recliner and prior to resident being lifted to provide a stationary lift point. During an interview on 3/17/26 at 11:17 a.m., restorative aide (RA) stated mandatory education on facility lifts was provided to the staff yearly, last time was July 2025. The facility has three different types of lifts: standing frame, stand up/PAL (SUL), and the full body lift. All the facility lifts were covered during annual education via verbal, skill labs, observation, and hands on. RA had not reviewed the manufacture's guidelines, but had taught staff the education on the lifts according to what RA learned from previous staff. RA state, "he learned as he went." A resident should have been assessed by therapy prior to lift machine use to provide safe transfers. The level of assistance a resident required would vary from resident to resident and was determined by a therapy evaluation. Staff would be expected to use the brakes on a lift during several actions, including when sling and loops were hooked up to the machine, so machine stayed steady, and things did not move around. Then, release the brakes before staff operated the motor and lifted the resident up so that the machine was able to move a bit to adjust to the resident. If a resident was left alone, hooked up to the lift machine such as in the bathroom, the brakes to the lift should have been		F0689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
F0689 SS = D	Continued from page 12 locked to keep the lift in a safe position, for resident comfort and to avoid resident's feet from hanging down on the floor. If a lift machine was not locked while the resident was still hooked to the lift, accident and/or injury could happen if the resident tried to get off toilet and their feet moved the SUL. Some residents would be ok left alone attached to the lift machine with the brakes on in the bathroom based on their cognition level. R4's cognition was intact and RA trusted R4 to know what she wanted. Staff should have stayed in her room while she was in the bathroom if she allowed. During an interview on 3/17/26 at 1:00 p.m., RN-B stated staff would be expected to have used the brakes on the SUL once the machine was placed in front of the resident. The lift sling would be placed around the resident, attached to the machine, sling belt pulled snug around the abdomen, and slowly lift the resident up. The brakes would be released until the resident was moved to where they wanted to go then brakes were required to be on, especially when lowered down. When a resident remained on the toilet and hooked up to the lift machine, RN-B expected the brakes to remain on so the SUL did not shift or move and pull resident off where they sat. The brakes on the SUL remained on while resident was lifted or lowered to avoid movement of machine and protentional injury to resident or staff. During an interview on 3/17/26 at 5:20 p.m., administrator stated staff were expected to have placed the brakes on the SUL right after it was positioned in front of the resident. The brakes to the SUL must be on while the resident was lifted to have provided stability and traction. Failure to have the brakes on when lifting the resident up could result in the resident falling and getting injured. The only time appropriate to release the breaks on the SUL would be upon movement of the machine going from point A to point B, just like a wheelchair. After a resident was transferred to the toilet and remained attached to lift, the brakes should have been placed on. Failure to do so could have resulted in the lift moving, becoming unstable and placed the resident at risk for falls and/or accidents. During an interview on 3/17/26 at 5:30 p.m., director of nursing (DON) stated she would have expected staff to have applied the brakes on the SUL while a resident was hooked up to the lift, when being lifted or lowered. DON expected the brakes were released to move the machine. DON compared the stand lift to a wheelchair. Without the brakes on, if something moved and created motion, the machine and/or wheelchair would		F0689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245265		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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
F0689 SS = D	Continued from page 13 scoot out from under the resident’s butt and could have resulted in a fall/accident. Application of the brakes was a must to provide a safe transfer. Alliance Stand Assist Lifts user manual dated 9/2013, identified lift and transfer from seated position. -fit sling as described in “fitting stand assist sling”. -Push lift towards patient. Open the base of the lift to go around the chair. Apply the brakes in both rear casters. -Position patient’s feet on the foot platform and knees against the knee pad. -Attach the sling straps to the hooks. -Have patient’s hands holding the handles. -Press the up button on the hand control. -Before the patient’s body is lifted from the chair, stop and make sure the sling is secured and patient’s knees are against the knee pad. -The patient should be comfortable with the pressure under the arms. If not, adjust the sling and try another loop option to release pressure. -Press the UP button until the patient’s body has completely left the chair. -Transfer to another object can be done at this position without the patient attending a full standing position. -Release the brakes, close the base, and pull the lift until the patient’s knees are locked in a standing position. -Lower the patient to the object intended.			F0689			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20000	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 3/12/26, 3/16/26, and 3/17/26 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			04/10/2026	

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20000	Continued from page 1 The following complaint was reviewed. H52657740C (2793268) with a licensing order issued 0830. 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.		20000				
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record, and manufacturer's instruction review the facility failed		20830	CORRECTED		04/21/2026	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20830	Continued from page 2 to follow manufacturer's instruction for 1 of 3 (R4) residents during a transfer with a stand lift. Findings include: R4's quarterly Minimum Data Set (MDS) dated 2/4/26, identified R4 had intact cognition and no behaviors. R4 required substantial/maximum assistance with shower/bathing, upper body dressing, personal hygiene, sit to stand, all transfers, dependent for toileting hygiene and lower body dressing, unable to walk and used a wheelchair for mobility. R4 was occasionally incontinent of bladder and always continent of bowel. R4's diagnoses included debility, cardiovascular conditions, hemiplegia/hemiparesis (weakness or paralysis on one side of the body), muscle spasms, osteoarthritis (protective cartilage that cushions the ends of the bones wears down over time), anxiety, height 62 inches (5 feet 1 inch), weight 238 pounds, body mass index (amount of body fat based on height and weight) 45.0 - 49.9 (over 40 was identified as morbid obesity). She was not receiving therapy (physical, occupational, restorative). No falls since admission. R4's care plan last updated on 1/29/26, identified high risk for falls related to obesity, osteopenia (reduction of bone density), chair bound, past fall, and polypharmacy (several medications taken each day). R4's muscle spasms better managed due to back on routine medications. Staff were directed to stay near but do not need to stay in bathroom. R4 had difficulty with elimination with staff close. R4 had an activity of daily living (ADL) self-care deficit related to hemiplegia and limited range of motion. R4 was unable to walk, and staff were directed to transfers with assist of one and bariatric SUL (stand up lift) (type of lift designed to assist individuals with limited mobility in transitioning from a seated to a standing position safely. Bariatric models are specially engineered to accommodate higher weight capacities, ensure safety, and comfort for larger patients), and assist with toileting and associated hygiene. Resident care sheet dated 3/5/26, identified R4 transferred with a bariatric SUL assist of one and assist of two as needed (PRN) and an XL sling. Additional instructions included, make sure lift legs are spread apart when transferring please. R4's fall risk assessment dated 1/21/26, identified R4 admitted to facility on 8/22/11, no falls, confined to a chair, required physical assistance to maintain balance while standing. Fall risk score 16 (high risk		20830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20830	Continued from page 3 16-20). R4’s physical therapy (PT) evaluation dated 2/6/26, identified precautions: left hemiplegia, inability to use left hand to functionally hold onto lift, left knee extension lacking 40 degrees from full extension due to pain. She required total dependence with attempts to initiate transfers. R4 was unable to use left upper extremity (LUE) to hold handle for support during transfer but was able to maintain position safely in sling with arm stretched out laterally during transfers and able to use lower extremities to attain partial standing position to allow transfer from wheelchair to toilet. She will benefit from continued PT treatment and further assessment of transfers to ensure safety and recommendations as necessary. During an observation on 3/16/26 at 3:38 p.m., nursing assistant (NA)-A pushed a bariatric SUL into R4’s room. R4 sat in her wheelchair. NA-A opened the legs of the lift machine and pushed it in front of the R4’s wheelchair. NA-A placed a royal blue trimmed in black sling around R4 and secured the belt closed around R4's waistline. NA-A stood in front of wheelchair while R4 pulled the sling belt strap tight, and hooked red loops to the second metal loop on the lift. NA-A did not engage the lift's brakes. NA-A pushed the lift button, raised R4 out of the wheelchair. R4 held onto the hand grip with only the right hand. R4’s left hand/arm was positioned horizontally straight out backwards from her body with thumb pointed down towards the floor. Her body was slightly slouched down, knees bent, butt pushed outwards from her body and appeared to hang from the lift. NA-A pulled the stand lift away from the wheelchair, moved the lever and brought the legs of the lift together, pushed the lift machine into the bathroom, and up to the toilet, pulled down R4's pants, and pushed the lift button to lower R4 onto the toilet. R4’s feet remained on lift platform and hooked up to lift machine via leg sling. NA-A instructed R4 to turn on call light when finished. NA-A did not engage lift stand brakes prior to leaving the bathroom and closing the bathroom door. NA-A sanitized hands, exited R4's room and closed the door. Five minutes later, R4 placed call light on and NA-A entered her room. NA-A pushed the lift button to lift R4 off the toilet with the stand lift machine. NA-A did not open the legs of the machine, pulled R4 away from the toilet, completed peri cares with gloves on, and pulled up R4's pants. NA-A pushed pushed the lift out of the bathroom, opened the legs of the lift to clear the wheelchair, and pushed the lift button to lower R4 into her wheelchair. NA-A did not engage the lift's brakes prior to lowering R4		20830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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
20830	Continued from page 4 into her wheelchair. NA-A removed the sling loops from the SUL and the transfer belt from R4's waist. NA-A pulled the lift machine away from the wheelchair, placed legs of lift back together, adjusted R4's clothing, sanitized hands and removed the SUL out of R4's room. During the observation, NA-A did not ask R4 if she wanted the brakes on the lift machine and R4 did not ask for the brakes to be engaged. During an interview on 3/12/26 at 11:35 a.m., R4 sat in her room in a motorized wheelchair, well-groomed and stated she lived at facility for 14 years. She required assistance to the bathroom and used a stand lift to transfer. R4 felt some of the new staff lacked knowledge, did not seem to know what to do at times, and transferred her too fast with the stand lift. R4 stated she asked them to slow down many times as she did not want to risk her safety. During an interview on 3/16/26 at 4:45 p.m., NA-A stated she had received education on the SULs, the floor manager demonstrated them for staff. Staff were expected to use the brakes on the SUL before the resident was hooked up to the machine and to keep the brakes engaged while lifting the resident up. It was expected, the brakes were disengaged once staff were ready to move the lift. NA-A stated the brakes should have been engaged prior to lowering R4 onto the toilet, but R4 did not like the brakes engaged. NA-A stated R4 felt, "trapped in," when brakes were engaged. NA-A stated it would have been important to use brakes on the SUL as the resident weighs down the machine, the wheels could have moved the machine away from R4 and resulted in an injury or fall. NA-A stated she received education, was told to engage the SUL brakes but did not do that with R4. NA-A stated she previously informed R4 it was important to engage the brakes but R4 still insisted she did not want them on. NA-A stated she used the brakes with all other residents and most likely should have used them while R4 sat in bathroom alone, and remained hooked up to the SUL, in case her feet moved the machine and caused a fall. During an interview on 3/17/26 at 10:20 a.m., registered nurse (RN)-A stated once staff positioned the SUL in front of the resident, they were expected to engage the brakes. The brakes would have helped lock the machine in place to avoid it from sliding side-to-side while the sling loops were being connected. The resident would be lifted off the chair, brakes disengaged and moved to the bathroom. Once resident was positioned in front of the toilet, RN-A expected the brakes were engaged before the resident was lowered onto toilet. If the resident remained			20830			

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20830	Continued from page 5 connected to the lift machine via sling, RN-A expected the brakes remained engaged. This was important as resident movement could have caused the SUL to move away and may have resulted in an accident/fall. The staff were expected to remain in the room to help prevent an accident. When a resident refused brakes to be engaged on the SUL, RN-A expected staff to educate the resident, safety always overrode the resident's request. During an interview on 3/17/26 at 10:56 a.m., clinical engineering (CE) stated he completed the facility lift inspections annually and as needed. Staff would be expected to have applied the brakes on the SUL after they opened the legs of the machine to go around the chair/recliner and prior to resident being lifted to provide a stationary lift point. During an interview on 3/17/26 at 11:17 a.m., restorative aide (RA) stated mandatory education on facility lifts was provided to the staff yearly, last time was July 2025. The facility has three different types of lifts: standing frame, stand up/PAL (SUL), and the full body lift. All the facility lifts were covered during annual education via verbal, skill labs, observation, and hands on. RA had not reviewed the manufacture's guidelines, but had taught staff the education on the lifts according to what RA learned from previous staff. RA state, "he learned as he went." A resident should have been assessed by therapy prior to lift machine use to provide safe transfers. The level of assistance a resident required would vary from resident to resident and was determined by a therapy evaluation. Staff would be expected to use the brakes on a lift during several actions, including when sling and loops were hooked up to the machine, so machine stayed steady, and things did not move around. Then, release the brakes before staff operated the motor and lifted the resident up so that the machine was able to move a bit to adjust to the resident. If a resident was left alone, hooked up to the lift machine such as in the bathroom, the brakes to the lift should have been locked to keep the lift in a safe position, for resident comfort and to avoid resident's feet from hanging down on the floor. If a lift machine was not locked while the resident was still hooked to the lift, accident and/or injury could happen if the resident tried to get off toilet and their feet moved the SUL. Some residents would be ok left alone attached to the lift machine with the brakes on in the bathroom based on their cognition level. R4's cognition was intact and RA trusted R4 to know what she wanted. Staff should have stayed in her room while she was in the bathroom if she allowed.		20830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20830	Continued from page 6 During an interview on 3/17/26 at 1:00 p.m., RN-B stated staff would be expected to have used the brakes on the SUL once the machine was placed in front of the resident. The lift sling would be placed around the resident, attached to the machine, sling belt pulled snug around the abdomen, and slowly lift the resident up. The brakes would be released until the resident was moved to where they wanted to go then brakes were required to be on, especially when lowered down. When a resident remained on the toilet and hooked up to the lift machine, RN-B expected the brakes to remain on so the SUL did not shift or move and pull resident off where they sat. The brakes on the SUL remained on while resident was lifted or lowered to avoid movement of machine and protentional injury to resident or staff. During an interview on 3/17/26 at 5:20 p.m., administrator stated staff were expected to have placed the brakes on the SUL right after it was positioned in front of the resident. The brakes to the SUL must be on while the resident was lifted to have provided stability and traction. Failure to have the brakes on when lifting the resident up could result in the resident falling and getting injured. The only time appropriate to release the breaks on the SUL would be upon movement of the machine going from point A to point B, just like a wheelchair. After a resident was transferred to the toilet and remained attached to lift, the brakes should have been placed on. Failure to do so could have resulted in the lift moving, becoming unstable and placed the resident at risk for falls and/or accidents. During an interview on 3/17/26 at 5:30 p.m., director of nursing (DON) stated she would have expected staff to have applied the brakes on the SUL while a resident was hooked up to the lift, when being lifted or lowered. DON expected the brakes were released to move the machine. DON compared the stand lift to a wheelchair. Without the brakes on, if something moved and created motion, the machine and/or wheelchair would scoot out from under the resident’s butt and could have resulted in a fall/accident. Application of the brakes was a must to provide a safe transfer. Alliance Stand Assist Lifts user manual dated 9/2013, identified lift and transfer from seated position. -fit sling as described in “fitting stand assist sling”. -Push lift towards patient. Open the base of the lift to go around the chair. Apply the brakes in both rear		20830				

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/17/2026	
NAME OF PROVIDER OR SUPPLIER ST FRANCIS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 ST FRANCIS DRIVE , BRECKENRIDGE, Minnesota, 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	
20830	Continued from page 7 casters. -Position patient's feet on the foot platform and knees against the knee pad. -Attach the sling straps to the hooks. -Have patient's hands holding the handles. -Press the up button on the hand control. -Before the patient's body is lifted from the chair, stop and make sure the sling is secured and patient's knees are against the knee pad. -The patient should be comfortable with the pressure under the arms. If not, adjust the sling and try another loop option to release pressure. -Press the UP button until the patient's body has completely left the chair. -Transfer to another object can be done at this position without the patient attending a full standing position. -Release the brakes, close the base, and pull the lift until the patient's knees are locked in a standing position. -Lower the patient to the object intended. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to mechanical lift transfers. The director of nursing or designee could provide education to the staff and conduct audits to ensure proper care is provided to residents. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days		20830				