Electronically delivered
February 28, 2019

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

RE: Project Number H5265014C and H5265015C

Dear Administrator:

On February 11, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments 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. In addition, at the time of the February 11, 2019 abbreviated standard survey the Minnesota Department of Health, completed an investigation of complaint number H5265015C that was found to be substantiated.

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. In addition, at the time of the February 11, 2019 abbreviated survey, the Minnesota Department of Health, completed an investigation of complaint number H5265014C that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is March 23, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 May 11, 2019 (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 August 11, 2019 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 02/11/2019

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 An abbreviated standard survey was conducted on February 11, 2019 to investigate complaints H5265014C and H5265015C. The complaint was found to be substantiated along with the related deficiency are as followings: H5265015C- Deficiency issued at F609. H5265014C was not substantiated The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §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	F 609		3/15/19

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

Electronically Signed | 03/06/2019

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.

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F 609	Continued From page 1 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 neglect were immediately reported, no later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury to the State Agency (SA), for 1 of 3 residents reviewed for potential neglect when a mechanical lift tipped during use. Findings include: R1's quarterly Minimum Data Set (MDS) dated, 11/11/18, identified R1 was cognitively intact and had diagnoses which included chronic kidney disease, congestive heart failure and obesity. The MDS identified R1 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers and toileting. The MDS identified R1 had no falls since the last quarterly assessment. Review of R1's facility incident report revised 1/2/19, at 5:00 p.m. revealed R1's family member had reported to the facility social worker (SW) that R1 had told the family member that a week or two prior, R1 had been transferred with the	F 609	All staff will be educated on need for immediate reporting of all incidents and deviations from resident□s care plan and to stop and listen to residents when they are questioning something with their care. This education will take place by 3/15/19. Staff will review care sheets for correct plan of care if needed. All staff will read education piece and sign acknowledgement of reading. DON will also review this information again with staff at monthly department meetings on 3/25/19. All neighborhood communication books were reviewed by DON for the past 3 months to look for potential incidents that were not reported. No other incidents noted. DON will complete weekly rounds conversing with staff on how mechanical lift transfers have been occurring. DON will continue to discuss immediate reporting of all incidents and deviations to staff during rounds. DON will complete	

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F 609	Continued From page 2 wrong mechanical lift. The family member reported R1 had told her she had been lifted out of bed with the mechanical lift, when the lift tipped and bumped her into the wall. The incident report revealed R1 had attempted to tell the nursing assistant (NA) the wrong lift was used, though R1 reported the NA had no listened. The incident report revealed R1 was able to recall one NA's name, but not the other. The incident report revealed R1 and her family member were unable to recall the exact date of the incident. Further, the incident report revealed R1's family member notified the facility SW at 4:20 p.m. and the administrator was notified at 4:43 p.m. Review of R1's Incident Report Investigation Summary, dated 1/4/19, revealed the facility had completed an investigation into the aforementioned incident and the following was identified; R1 had been transferred with a mechanical lift on 12/22/18, in which the mechanical lift had tipped and R1 subsequently bumped into the wall. The investigation summary revealed facility staff were to assist R1 to transfer with a bariatric mechanical lift. The summary revealed facility staff had not followed R1's care plan and used a full body mechanical lift versus a bariatric lift. R1's investigation summary revealed the facility NA's had not reported the incident to the charge nurse on duty or to any other facility staff. On 2/11/19, at 3:20 p.m. R1's incident reporting investigation report summary dated 1/4/19, was reviewed with the director of nursing (DON.) The DON confirmed the NA's involved in the R1's transfer did not follow the facility's policy for internal reporting and indicated she expected all incidents and deviation from residents care plan	F 609	weekly rounds conversing with residents on how they feel cares are being completed and if they feel they are completed correctly as care planned. This will take place for a 3 month period. The DON will continue with these audits monthly thereafter. DON will report audit findings to the QAPI committee after the 3 month audit period. Social services will monitor whether incidents of potential neglect are reported in a timely manner per policy. A quality control report is completed along with monthly review of all incidents noting if reporting was completed on time or not. This will continue to be reported to the QAPI Committee quarterly. DON will complete weekly rounds conversing with staff on how mechanical lift transfers have been occurring. DON will continue to discuss immediate reporting of all incidents and deviations to staff during rounds. DON will complete weekly rounds conversing with residents on how they feel cares are being completed and if they feel they are completed correctly as care planned. This will take place for a 3 month period. The DON will continue with these audits monthly thereafter. DON will report audit findings to the QAPI committee after the 3 month audit period. Responsible: DON	

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F 609	Continued From page 3 were to be reported immediately to the charge nurse, social worker, DON and administrator. The DON stated she had been unaware of the incident until R1's family member reported it the facility SW on 1/2/19. Further, the DON stated both of the NA's involved in R1's transfer had received education to let the nurse know of incidents for safety and had also received education on use of appropriate mechanical lifts for resident transfers. Review of the facility's policy titled: Vulnerable Adult Abuse and Neglect Reporting revised 2/18, revealed the facility was to notify the SA immediately, not to exceed two hours for cases of suspected abuse, neglect or mistreatment and/or major injury. Further, the facility policy revealed the facility was to notify the SA immediately, not to exceed 24 hours after knowledge of the incident, when no serious/major injury or abuse had been suspected/occurred.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 28, 2019

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

Re: Complaint Number H5265014C and H5265015C

Dear Administrator:

An abbreviated standard survey was completed on February 11, 2019 to investigate complaint numbers H5265014C and H5265015C. At the time of the abbreviated survey, the surveyor also assessed compliance with Minnesota Department of Health Nursing Home Rules. The surveyor from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

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. Enclosed is the Minnesota Department of Health order form stating that no violations were noted at the time of this investigation.

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

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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	00818	A. BUILDING: _____ B. WING _____	C 02/11/2019

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

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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 February 11, 2019, a surveyor of this Department's staff visited the above provider for a complaint investigation to investigate complaints H5265014C and H5265015C . No correction orders were issued. The facility is enrolled in ePOC and therefore a	2 000		

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2 000	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction in required, it is required that you acknowledge receipt of the electronic documents.	2 000		