STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, MN 56520	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to provide a comprehensive assessment by therapy for 1 of 3 residents (R3) to 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 [DATE], 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 [DATE], 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 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) (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1/4 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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 [DATE], 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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 (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.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 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.