STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245265	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and document review, the facility failed to provide assistance with routine grooming cares which included oral cares for 1 of 2 residents (R34) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene.Findings Include: R34's quarterly Minimum Data Set (MD) dated 4/28/26, identified R34 had severe cognitive impairment with diagnoses which included: Alzheimer's disease, anxiety and depression. R34's MDS identified R34 was dependent on staff for eating, oral hygiene, personal hygiene, and dressing. R34's care plan revised 5/13/26, identified R34 had self-care performance deficit related to Alzheimer's disease and dementia along with Impaired balance and weakness. R34 required total assistance of one with oral care and had own teeth in good condition. During telephone interview on 6/8/26 at 2:30 p.m., family member (FM)-A indicated they did not think staff routinely brushed R34's teeth. FM-A stated I think they do floss occasionally, but do not brush R34's teeth often enough. During observation on 6/9/26 at 7:06 a.m., nursing assistant (NA)-A was in R34's room attaching a sling for the stand- up lift to R34 while R34 sat on the edge of bed with assistance. At 7:07 a.m., NA-B entered room and assisted NA-A with the stand-up lift for R34, then they assisted R34 to the bathroom. NA-B left the room, then NA-A assisted R34 with washing and drying upper half of body, then applied R34's shirt and deodorant. At 7:16 a.m. NA-B came into R34's room and completed perineal cares, applied new brief and pants. NA-B assisted NA-A to transfer R34 to her wheelchair. NA-B left the room, then NA-A combed R34's hair, and applied perfume. NA-A made R34's bed, bagged up soiled clothing, linen, and garbage. NA-A wheeled R34 out to the common area near the TV. NA-A then sanitized hands. NA-A returned to room and disposed of soiled clothing, linens and garbage in soiled utility room. NA-A did not offer or complete oral cares for R34. At 8:12 a.m. R34 was assisted to the dining room, where staff fed her breakfast. During interview on 6/9/26 at 8:56 a.m., NA-A verified he did not offer to complete R34's oral cares or to brush R34's teeth. NA-A indicated he usually worked pm shift until a few weeks ago and was not used to morning cares. NA-B stated his usual practice was to complete oral cares in the evening. NA-A stated it was important to complete oral cares, so residents did not get cavities. NA-A stated it was difficult to be observed completing cares and most residents had dentures, so he was used to rinsing and applying dentures for residents in morning. During interview on 6/9/26 at 11:04 a.m., registered nurse (RN)-A stated expectation was for oral cares and brushing of teeth to be done with morning and evening cares. RN-A indicated oral cares were important, so residents did not develop infections, and for good oral hygiene. Director of Nursing (DON) was not available for an interview. The facility policy titled Grooming For Residents, undated, identified All residents would receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing manifested in part by being fully groomed. Residents who had their own teeth should have their teeth brushed every morning, every evening and as needed (PRN).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and document review, the facility failed to ensure staff were completing hand hygiene and using proper personal protective equipment (PPE) according to the Centers for Disease Control (CDC) guidelines for enhanced barrier precautions (EBP) while performing activities of daily living (ADLs) for 1 of 1 residents (R2) observed for EBP.Findings Include:R2's quarterly Minimum Data Set (MD) dated 6/4/26, identified R2 had paraplegia (loss of control of lower part of the body) and multiple sclerosis (an auto immune disease that affects the central nervous system). R2's MDS further identified R2 had an indwelling catheter and colostomy. R2's MDS revealed R2 was dependent on staff for personal hygiene, dressing, and transfers.R2's care plan revised 6/5/26, identified R2 had a history of infections and was on EBP per CDC infection prevention guidelines due to R2's indwelling catheter.R2's room door displayed a sign informing staff that R2 was on EBP. R2's door also provided a hanging cabinet that contained yellow gowns and gloves.Review of the CDC guidance dated 4/2/26, Implementation of PPE use in Nursing Homes to Prevent Spread of Multidrug-resistant organisms (MDRO), EBP are an infection control intervention designated to reduce transmission of resistant organisms that employes targeted gown and glove use during high contact resident care activities.During an interview and observation on 6/9/26 from 9:06 a.m. to 9:34 a.m., NA-A stated staff were going to get R2 up and dressed to go to breakfast. NA-A entered R2s room grabbed a pair of gloves from the hanging cabinet on R2s door and applied them. NA-A grabbed washcloths and towels out of R2s closet. NA-A grabbed the wash basins with supplies to provide personal hygiene for R2. NA-A removed R2's gown, checked R2's colostomy to ensure it was intact. NA-A removed gloves and applied a new pair of gloves. NA-A covered R2 up with a sheet and grabbed a pair of grey sweatpants and gold shirt out of R2's closet. NA-A filled R2's wash basin up and brought it out to the bedside table. NA-A removed R2's pressure relieving boots and two pillows under each side of R2. NA-A placed the washcloth into the basin and wrung it out. NA-A handed R2 the washcloth to wash R2's face and hands. NA-A took wash cloth from R2 placed put it in the basin and handed R2 a towel to dry face and hands. NA-A grabbed the washcloth wrung it out and washed R2's armpits. NA-A put the washcloth in the bag and the floor and dried R2's armpits. NA-A applied deodorant to R2's armpits and the applied R2's shirt. NA-A took another washcloth and placed it in the wash basin. NA-A wrung out the washcloth and washed R2's groin area. NA-A put the washcloth back into the wash basin and dried R2's groin area with a towel. NA-A removed gloves and applied new gloves. NA-A went to the right side of the bed and pulled the lift sheet under R2 to prepare R2 to roll to R2's side. NA-B entered the room to assist NA-A to roll R2 to R2's side. NA-B applied one glove and assisted NA-A to roll R2. NA-A wrung out the washcloth and washed R2's coccyx area. NA-B applied second glove. NA-A put the washcloth into the bag on the floor and dried R2's bottom with a towel. NA-A put the towel into the bag on the floor. NA-A applied barrier cream to R2's bottom. NA-A removed gloves and applied new gloves. NA-B removed gloves. NA-A grabbed R2s sweatpants and put them on R2s legs. NA-A and NA-B rolled R2 from side to side to get R2s pants up and place sling under R2. NA-A went to the bathroom to grab a graduate. NA-A emptied R2's catheter, dumped the urine into the toilet, and rinsed the graduate out. NA-A removed gloves and applied new gloves. NA-B removed one glove, pulled paper out of pocket, wrote urine amount on paper, and placed paper back into pocket. NA-B removed gloves. NA-A tied up bag and the floor and left the room to get the lift. NA-A and NA-B hooked sling up to lift and transported R2 to electric wheelchair. NA-A removed gloves, sanitized hands and left the room with the lift. NA-B sanitized hands, grabbed the bag on the floor and left the room. NA-A returned to R2's room and assisted R2 with combing R2's hair. NA-A made R2s bed and placed a new trashcan liner in bin. R2 left room in electric scooter to go to breakfast. NA-A and NA-B did not wear gowns or sanitize their hand between glove changes.During an interview on 6/9/26 at 9:30 a.m., nursing assistant (NA)-B indicated NA-B was aware R2 was on EBP and NA-B did not wear proper PPE while providing personal cares for R2. NA-B further indicated NA-B (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not sanitize hands during glove changes.During an interview on 6/9/26 at 9:36 a.m., NA-A indicated NA-A should have been wearing a gown when NA-A provided personal cares for R2. NA-A stated NA-A was aware R2 was on EBP and staff were supposed to use PPE when providing personal cares. NA-A further stated NA-A did not sanitize hands between glove changes. NA-A indicated NA-A thought about putting a gown on but did not want to stop cares for R2.During an interview on 6/9/26 at 10:33 a.m. registered nurse (RN)-B indicated R2 was on EBP and staff were expected to be putting on gowns, gloves and completing hand hygiene while providing R2's personal cares.During an interview on 6/09/2026 at 10:42 a.m., RN-A indicated RN-A assisted with infection control and had talked to staff about following EBP. RN-A further indicated EBP was discussed at meetings and staff received training on how to follow EBP.During an interview on 6/9/2026 at 10:47 a.m., administrator and vice president (VP) of patient services indicated the importance of EBP was to protect the residents and staff. Administrator and VP of patient services stated they would both expect staff to be compliant and follow EBP when providing personal cares to residents who are on EBP.Facility policy titled Isolation Precautions dated 11/22, identified healthcare personnel will utilize enhanced barrier precautions with all patient care activities to minimize exposure to potential pathogens as recommended by The Centers for Disease Control and Prevention (CDC). EBP was to be used with all residents have wounds and/or indwelling medical devices (urinary catheter).