



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2026

Administrator

ST JOHN LUTHERAN HOME
201 SOUTH COUNTY ROAD 5
SPRINGFIELD, MN 56087

RE: CCN:245407

Cycle Start Date: June 3, 2026

Dear Administrator:

On June 3, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

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 September 3, 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 December 3, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026		
NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH COUNTY ROAD 5 , SPRINGFIELD, Minnesota, 56087				
(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	
E0000	Initial Comments On 6/1/26 through 6/3/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			06/25/2026	
F0000	INITIAL COMMENTS On 6/1/26 through 6/3/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.			F0000				07/24/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -			F0812				

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

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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen and walk-in cooler was clean and free of food-like debris. In addition, kitchen staff failed to consistently log dishwasher temps to ensure proper sanitation and failed to date meat when placed in the walk-in cooler to thaw. This had the potential to affect all 51 residents. Findings include: FOOD STORAGE/KITCHEN CLEANLINESS Observation on 6/1/26 at 10:55 a.m., in the kitchen identified: The stove-top had food crumbs and a dried liquid on and between the burners and the wall behind the stove had food debris splashed upon the wall. A utility box mounted on the wall to the right of the stove was covered with a heavy layer of dust, mixed with food particles. A food prep counter near the sink had a radio that was covered in dust and food debris splatter. The office area connected to the kitchen had a countertop with a microwave, toaster, open partially used container of peanut butter, a large partially used plastic container of butter, and half of a loaf of bread. The countertop also had phone chargers, staff personal drink tumblers, change, a stapler,	F0812	Continued from page 1 The dietary manager, along with the RDN and the facility administrator have begun audits of sanitation, logs and full kitchen standards. Dietary manager will audit weekly, additional audits conducted by RDN or building administrator will be conducted as follows: Audits will be done weekly for the first month, bi-weekly for the second month, and monthly thereafter. Audits done for the cleaning lists will also include checking that all items in cooler are labeled/dated. The dirty radio in the kitchen has been discarded, and a new handsfree speaker will be purchased and added to the weekly cleaning list. The microwave and toaster were moved to an available space in the kitchen and will no longer be housed outside the hairnet area. No staff foods will be heated in this microwave. All beverages that are poured ahead of time will be dated appropriately. The dietary manager will purchase label guns; these label guns will be utilized by July 1st. Staff education provided on logging temperatures, washing dishes process and using dishwasher, cleaning duties, logging temperatures, dating items, and keeping staff and resident food items separate. Mandatory monthly in-services have been planned by the dietary manager. A rotating topic is planned for the entire year including but not limited to: ice-bath/proper cooling of cooked food, importance of cleaning log completion, and dishwashing sanitization. The policy for "Food Preparation and Handling" updated to include process for dating foods pulled from the freezer to be thawed. Dishwasher policy/procedure will be submitted for review. These will be reviewed and updated on an annual basis, more frequently if needed. Job descriptions updated to ensure they include everything expected to be done as stated by the weekly cleaning lists. All dietary staff will review and sign the updated job descriptions. Disciplinary action will be enforced if cleaning tasks and logging temperatures continue to be in noncompliance. Audit results will be reviewed at monthly QAPI meeting for further recommendations. Administrator or designee will monitor overall	07/24/2026

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F0812 SS = F	Continued from page 2 magazines, clip boards, pens, and other postal mail laying on the counter and on top of the microwave. There was no indication this area was not used for resident food preparation or reheating. Inside the walk-in cooler there was shredded cheese, onion peels, crumbs, and other unknown debris scattered throughout onto the floor. The walls behind the shelving had splatters of an unknown substance and the floor below a shelf (approximately 1-2 feet up the wall from the floor) had a black, spotted, mildew-like substance. The walk-in cooler had a large beef roast on the second to bottom shelf that was contained in a sealed plastic wrap, was soft to the touch and appeared fully thawed. There was also 2 large boxes containing additional beef roasts that were placed in the cooler to thaw that had no date when it was placed into the cooler. The bottom shelf had a ham roast that was also thawing, again, with no date when it had been placed into the cooler. On the upper shelf above the thawing meat listed above, were several cooked chicken legs that were not covered or dated. Next to the chicken was a small steamtable tin left uncovered containing a white creamy substance, that was not labeled with its contents, nor was it dated. There were 4 free standing carts observed against the wall inside the cooler with large clear plastic cover over them. The carts had trays with a variety of items, such as single servings of desserts in small dishes, pureed bread, mixed fruit, glasses of white and chocolate milk, and glasses of juice. On the outside of the cover, the carts were labeled “breakfast”, “lunch”, “supper”. None of the food items on the carts were dated to identify when they had been removed from the original container or when they should be discarded if they were not used. Interview on 6/1/26 at 11:12 a.m., with dietary aid (DA)-A identified he agreed none of the previously mentioned food items had been dated. Dietary staff set up the carts for meal service and he identified some of the items on the carts that were set up yesterday and some of the items were set up today. He was not certain when the beef and ham roasts had been placed in the cooler to thaw and believed the chicken legs in the tin pan had been in the cooler for “a couple days”. He identified the white creamy substance in the small pan next to the chicken was pureed chicken and agreed the pan should have been covered and dated. Review of the cleaning logs for May of 2026, identified 3 different detailed list of kitchen areas to			F0812	Continued from page 2 compliance.		07/24/2026

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F0812 SS = F	Continued from page 3 be cleaned and sanitized such as food prep counters, back splash, appliances, floors, coolers, and garbage. One of the lists noted staff had completed cleaning duties for 3 of 31 days, another list noted staff had completed cleaning duties for 8 of 31 days. Review of the undated General Food Preparation and Handling policy identified the kitchen was to be neat and orderly, kitchen surfaces and equipment would be cleaned and sanitized as appropriate. Food will be covered when in storage and cooked as soon as possible after thawing. Meats, fish and poultry will be defrosted using safe thawing practices. The policy made no mention of dating foods pulled from the freezer to be thawed. Review of the undated Cleaning and Sanitation of Dining and Food Service Areas Policy identified staff were to: Keep all food service areas clean, sanitary, free from litter, and rubbish. Tasks shall be designated to be the responsibility of specific positions in the department. A cleaning schedule would be posted for all cleaning tasks and staff would initial the task as completed. The director of food and nutrition services would perform inspections of the food service areas to ensure all cleaning and sanitation tasks are being completed. Sanitation inspections would be conducted daily by food service staff and weekly by the dietary manager to ensure the areas are clean and comply with sanitation and food service regulations. DISHWASHER Interview on 6/1/2026 at 11:20 a.m., with DA-B said she was one of the staff who washes dishes. She was not sure if the dishwasher sanitized by heat or chemical, but said that the monitor on the dishwasher says “sanitizing” and that was how she knew the sanitization was being completed. She said the dishwashing staff were to log the temperatures on the log sheet at each meal service but was not certain of the purpose of that process. She said she puts “blue stuff” she thought might be a sanitizer in a tub of water that she soaks the dishes in and “if it			F0812			07/24/2026

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F0812 SS = F	Continued from page 4 isn't blue enough" she adds more. Observation on 6/1/26 at 11:20 of the "blue stuff" DA-B was soaking the dishes in was not a sanitizer rather it was an enzymatic pre-soak commonly use as an aid to remove debris from dishes. Review of the May 2026 Dishwasher Temperature log identified the dishwasher sanitized through heat, and not chemical had a column for each meal service for staff to log dish wash and rinse temperatures for ensuring proper sanitization of the dishes. For the breakfast service, the temperatures were only logged for 4 of 31 days. for lunch service, the temperatures were logged for 3 of 31 days. The supper meal service, temperatures were logged for 26 of 31 days. Interview on 6/2/26 at 10:20 a.m., with the dietary manager (DM) identified she agreed with the above findings, she "had no idea" when the ham and beef roasts had been placed in the cooler to thaw and identified she would discard the meat as it was not safe to eat. It was her expectation that staff would date the meat when it was pulled from the freezer. She expected staff to complete cleaning in the kitchen daily and initial the cleaning logs as the duties were completed. The DM said the counter in the office where the microwave and toaster were located had been used to prepare and warm resident food and occasionally was used by staff to make toast for themselves. Interview on 6/2/26 at 10:27 a.m., with the registered dietitian (RD) identified, she comes to the facility every Tuesday. She had been in the kitchen today and agreed with the above findings. She identified she had not completed an audit or walk through of the kitchen since approximately December but had completed one earlier that day after being updated of the concerns noted above. The RD identified following her walk through "I definitely need to start doing weekly audits again". In addition, she identified the kitchen needed some "deep cleaning" and staff would need to be re-educated. The RD said in the office area where the microwave and toaster were, it was not acceptable to be used for preparing food for residents in any area where staff personal supplies were used or stored. She was not aware this was happening until today. She further identified she had directed the DM to discard all the undated meat that was in the walk-in cooler for thawing and that this			F0812			07/24/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0812 SS = F	Continued from page 5 had been completed.	F0812		07/24/2026
F0865 SS = F	A dishwasher policy and procedure or manufacturer's instructions for use on the dishwasher was requested but not provided by the end of the survey period. QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be	F0865	QAPI committee reviewed facility QAPI program plan. Meeting templates revised to include measurable goals, benchmarks, analysis of data, action plans, assigned responsibilities, and monitoring of outcomes. All residents had potential to be affected. All active QAPI projects were reviewed to ensure data analysis and monitoring processes. Implemented a standardized QAPI meeting template that includes data analysis, root cause, measurable goals, action plans, assigned responsibilities, evaluation of interventions. Education of all leadership and QAPI members on CMS QAPI requirements and documentation expectations at next meeting. Next QAPI meeting is scheduled for 7/15/26. Administrator and Director of Nursing will audit QAPI meeting minutes monthly to ensure goals, interventions, outcomes and evaluations are discussed. Findings will be reported at next QAA meeting. Administrator, Director of Nursing or designee will oversee compliance.	07/24/2026

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F0865 SS = F	Continued from page 6 ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and			F0865			07/24/2026

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F0865 SS = F	Continued from page 7 §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance Program Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 51 residents. Findings include: Review of the designated quarterly QAPI meetings from June 2025 through April 2026 identified facility departments were submitting data for review by the committee, but the minutes lacked evidence of measurable goals, discussion of the data submitted, and a plan of action for improvement. Examples included: The June 18, 2025, QAPI meeting minutes identified the facility monitored areas such as: Falls: 13 falls occurred, which was down from the previous month with 4 residents (unknown) having repeated falls. The goal was to decrease falls. There were no major injuries noted with actions to continue to review each fall and new intervention in place. There was no indication who the residents involved were, if the facility was monitoring those falls to ensure interventions were followed, if there was a need to alter interventions, if potential commonalities with residents and their falls (hours of day, shifts when they occurred, etc.) were reviewed, or how they intended to meet their goal or			F0865			07/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH COUNTY ROAD 5 , SPRINGFIELD, Minnesota, 56087			
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F0865 SS = F	Continued from page 8 what the benchmark was. Alarms: Staff noted there was a decrease from the previous month and staff were to continue to attempt to decrease the number of alarms. There was no indication of what the goal was, how the facility would reach their goal, or how they were going to implement their action plan or monitor its progress. Skin: Staff noted they had 2 (residents) with pressure ulcers (PU). QAPI would continue to monitor. There was no documentation to identify what the benchmark and goals were, how the facility would reach their goal, or how they identified they would monitor the PU. Weights: The goal was to improve weight charting and monitor for accuracy. They had noted improvements occurred in charting and they had added a note to the electronic treatment record for the nurse to review and they would continue to monitor. There was no resident specific information noted to have been discussed as to whether or not the weights being monitored were high impact resident risk areas such as severe weight loss with specific residents, or if this was an overall problem with staff obtaining and documenting weights in the treatment record. Antipsychotics: 9 residents were noted to be on antipsychotics. 2 were on hospice. The facility noted they would continue to work on decreasing antipsychotics with the psychiatric provider. There was no indication if QAPI reviewed specific residents to determine if the antipsychotics were appropriately prescribed, if they were being appropriately monitored, and if non-pharmacological interventions had been tried and were appropriate. The July 25, 2025 meeting minutes identified each department area brought forth data to QAPI. Infection control, for example, had listed the number of infections, however there was no evaluation of that data, if the infections had commonalities in surveillance, what goals and benchmarks were, or how the facility was ensuring the infection preventionist was appropriately surveilling the facility. Skin areas were also discussed and were similar to the previous month's review with a lack of documented discussion or data analysis, and antipsychotics were noted with the same goal to decrease their use for residents', but there was no information as to how the facility would reach that goal, or if specifics for residents were discussed.			F0865			07/24/2026

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F0865 SS = F	Continued from page 9 The September 17, 2025, December 2025, March 2026, and April 2026 meeting minutes identified each area brough forth data to QAPI were similar to those minutes above with missing goals, benchmarks for how the facility was performing with other facility's in the State or Nation, if they had reviewed specific residents' circumstances, how they would achieve their goals, if their limited documented actions had been successful from the previous months, if there was a need for change, or how long the facility needed to monitor each area brought forth. The Performance Improvement Project (PIP) for 2026 was moderate to severe pain in long stay residents. There was no data to identify the need for the project, discussion with rational for choosing the project, measurable goals, and development of a plan of action for the project. Overall, there was no documentation in the above-mentioned QAPI minutes to support the QAPI committee set benchmarks or measurable goals, thoroughly analyzed the data brought forward, how they were going to achieve their goals, if further education was needed, or if specific staff required retraining etc. Interview on 6/3/26 at 3:39 p.m. with the facility administrator and director of nursing regarding the QAPI program identified department heads provided data that was included in the meeting minutes, but there was no discussion, establishment of measurable goals, or plan of action developed and documented in the meeting minutes. The Administrator identified the QAPI committee had chosen moderate to severe pain in long stay residents as the 2026 project. She identified the QAPI minutes had no discussion, analysis of data, implementation of an action plan nor a measurable goal established in the five months since the beginning of 2026. Review of the January 2026, QAPI Plan identified the administrator as responsible to ensure the QAPI plan was reviewed at least annually. Revisions were to be implemented to identify and address issues identified in the organization. The facility provided services which impacted care and services to all residents living in the facility community. The committee was to utilize evidence-based practices and data to define goals and implement plans of action. The administrator and DON were designated as having responsibility for leading and directing the			F0865			07/24/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0865 SS = F	Continued from page 10 QAPI program. Performance Improvement Projects (PIPS) were to have a project charter developed at the beginning of the project that established goals, scope, timing, milestones, team roles, and responsibilities. Information was to be discussed during QAPI meetings with monitoring, analysis of the identified problem, and indication for changes. To promote improvement the organization was to develop actions to address the root cause and contributing factors that would affect the identified issue.	F0865		07/24/2026	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow physician orders to measure a pressure ulcer weekly and follow their policy and procedure on documenting pressure ulcer care for 1 of 1 sampled resident (R8). Findings include: R8's quarterly, Minimum Data Set (MDS) assessment, accepted on 5/19/26 identified R8's cognition was moderately impaired, and she required substantial assistance with care, bed mobility and transfers. R8 had a life expectancy of 6 months or less and was on hospice. R8 had pain and within the assessment period, had reported her pain was severe. R8 took scheduled pain medication and as-needed pain medication. R8 was identified as	F0686	Pressure ulcer for R8 was measured and documented. Audited all residents with pressure ulcers for weekly documentation. Developed Pressure Injury Prevention and Management policy and procedure. Implemented weekly wound monitoring process using weekly wound assessment form and pressure injury tracking form. Weekly wound measurements and documentation added to ETAR for residents with pressure injuries. Pressure ulcers will be reviewed weekly at IDT stand up meetings. Training to licensed staff on Pressure Injury Prevention and Management policy, weekly wound assessment form and required weekly documentation. Director of Nursing or designee will audit all residents with pressure ulcers for documentation weekly x 8 weeks and monthly thereafter. Audit results will be reported to the QAPI committee x3 months or until sustained compliance achieved. Director of Nursing or designee will oversee compliance.	07/24/2026	

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F0686 SS = D	Continued from page 11 having a Stage 2 pressure ulcer with a pressure relieving device in her chair and on the bed. Observation and interview on 6/2/26 at 8:55 a.m., with registered nurse (RN)-A who performed a dressing change to R8's thoracic spine identified RN-A removed the old dressing and cleansed the area. The wound measured 0.7 centimeters (cm) x 0.4 cm. RN-A described the wound as superficial with a red wound bed and well-defined edges. RN-A reported she did not note any signs or symptoms of an infection and applied a new dressing. RN-A stated weekly wound documentation was completed in the progress notes. R8's 11/18/25, physician telephone order identified: Staff were to give Arginaid (wound healing supplement) and mix with a 4-ounce beverage twice a day until the wound resolved. Staff were to change R8'S dressing to her thoracic (upper middle area) spine Tuesday and Saturday morning after her bath and measure the wound on Tuesdays until healed. Review of nursing progress notes from 3/1/26 through 5/31/26 identified there were 5 weeks the facility did not follow the physician orders to measure weekly or document pressure ulcer assessments per policy. For the week of; 3/22/26 through 3/28/26, there had been no wound documentation or measurement. 4/12/26 through 4/18/26, a note identified on 4/18/26 R8's Mepilex dressing had been removed and a new one applied. The note lacked a description or measurement of the wound. 5/3/26 through 5/9/26, a note identified on 5/3/26, a treatment had been done to R8's mid back and a new foam dressing had been applied, with no drainage noted. The note lacked a description or measurement of the wound. On 5/9/26, a progress note identified a new foam dressing had been applied to bony prominence of mid back, with no signs or symptoms of infection. That note lacked a description or measurement of the wound. 5/17/26 through 5/23/26, a note identified on 5/23/26, that no redness or edema was noted. A new foam dressing had been applied to R8'S mid			F0686			07/24/2026

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F0686 SS = D	Continued from page 12 back, showing no signs or symptoms of infection. The note lacked a description or measurement of the wound. 5/24/26 through 5/30/26, there had been no wound documentation or measurement. Interview on 6/3/26 at 10:35 a.m., with RN-C identified, the nurse should be documenting and measuring a pressure ulcer weekly. Interview on 6/3/26 at 11:40 a.m., with RN-B identified the nurse was to assess and measure R8's wound weekly on her bath day and document that in the progress notes. Interview on 6/3/26 at 2:05 p.m., with director of nursing identified staff were to monitor R8's pressure ulcer weekly and notify the physician if the wound was not improving or was worsening. Her expectation was that R8's or any other resident's pressure ulcer would be assessed weekly with measurements to monitor any need to alter the treatment. Review of the November 2025, Pressure Ulcer/Skin Breakdown Clinical Protocol policy identified the nurse would monitor pressure ulcers weekly. The nurse was to describe and document the pressure ulcer location, stage, length, width, depth, surrounding tissue, and wound bed and document the residents' pain, mobility, current treatments and active diagnoses.			F0686			07/24/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility			F0881	Resident had already completed antibiotic. All residents have the potential to be affected. Implemented 72hr antibiotic time out form. Added standing order in electronic health record for antibiotic time out. Revised Antibiotic Stewardship policy to include the use of the 72hr antibiotic time out form. Education of licensed staff and ward clerks on Antibiotic Stewardship policy, use of 72hr time out form and adding the 72hr antibiotic time out to the ETAR as a reminder. Infection preventionist will monitor all antibiotic orders and time outs. This will be tracked on the Antibiotic tracking log. Antibiotic use will be reviewed weekly at IDT stand up meeting. Audits of antibiotic time out will be completed weekly x 4 then monthly x 3. Audit results will be reviewed by the		07/24/2026

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F0881 SS = D	Continued from page 13 failed to perform antibiotic stewardship to include a system for monitoring and reducing antibiotic resistance. In addition, the facility failed to follow their policy on antibiotic stewardship and conduct an antibiotic timeout (ATO) for 1 of 3 sampled residents (R52). Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out." Review of the Resident Antibiotic Tracking forms from February 2026 through May 2026 identified in the section Antibiotic Reassessment (Antibiotic "Timeouts") preformed yes or no, was left blank each month. Review of February 2026, Antibiotic Tracking form identified R52 had symptoms of behaviors, incontinence, a fall, and cloudy urine with an onset date of 2/18/26. A urinalysis and culture were completed and R52 was identified as having a urinary tract infection (UTI). R52 started on Ciprofloxacin 500 milligrams (mg) orally twice a day for 7 days starting on 2/19/26 and finishing the antibiotic on 2/25/26 and symptoms resolved on 2/26/26. There was no indication that an ATO had been completed. R52's 2/19/26, physician order identified Cipro 500 mg by mouth for 7 days for UTI. Interview on 6/2/26 at 2:30 p.m., with registered nurse (RN)-D identified the facility "kind of" completed ATO's. The nurse was to notify the provider if the resident did not seem to be getting better and the nurse would make a note about that.			F0881	Continued from page 13 QAPI committee for further recommendation. Director of Nursing or designee will monitor overall compliance.		07/24/2026

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F0881 SS = D	Continued from page 14 The facility did not “have a form or anything that they use”, they would “just make a progress note”. Review of R52’s progress notes from 2/15/26 through 2/27/26 identified on: 2/15/26, multiple behaviors had been charted. 2/19/26, R52 was found on floor at 0030 during routine rounds. 2/19/26, at 4:45 p.m., a note identified an order for urinalysis and urine culture. 2/19/26, at 5:14 p.m., a note identified R52 had UTI and received an order for antibiotics. 2/20/26, at 11:20 a.m., R52 was sleeping heavily, did not eat breakfast, was toileted and repositioned every 2 hours, sat in the recliner, and had not taken medications. 2/20/26, at 1:04 p.m., R52 took bites for lunch and took some of her medications. 2/21/26, at 6:03 a.m., R52 was awake for bath and given last evening's antibiotic. 2/22/26, at 6:02 a.m., R52 was awake and took last evenings antibiotic crushed and mixed with ice and grape juice. 2/23/26, at 10:49 a.m., R52’s culture was noted abnormal, and staff were to continue with current antibiotic, (5 days after starting the antibiotic). 2/27/26, at 8:45 a.m., the antibiotic course was completed for R52’s UTI (on 2/25/26). Interview on 6/3/26 at 10:05 a.m., with RN-D confirmed the facility did have any type of form they used to document an antibiotic timeout. The facility did communicate to the physician about culture and sensitivity results. There should be a progress note, but the facility “could do better” on antibiotic stewardship and let the provider know how the resident was responding to an antibiotic. RN-D revealed the nurse practitioner came to the facility sometimes 3 times a week and could review the antibiotic timeout information on those days. RN-D confirmed that there was no consistent review of antibiotics.			F0881			07/24/2026

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F0881 SS = D	Continued from page 15 Interview on 6/3/26 at 11:00 with RN-C identified the facility did not do any type of ATO's after starting an antibiotic. Interview on 6/3/26 at 11:03 a.m., with RN-B identified as a nurse, she always followed up with the physician after a resident finished an antibiotic. She always tried to follow up with the provider to let them know if the resident symptoms resolved or continued after finishing the antibiotic and did not mention the need to perform an ATO between 48-72 hours after initiation. Interview on 6/3/26 at 2:05 p.m., with the director of nursing identified that she would expect staff would be following their antibiotic stewardship policy and completing ATO's. Review of the undated, Antibiotic Stewardship policy identified the facility had protocols and systems to monitor antibiotic use. Part of that system included an "antibiotic timeout" which the nurse would monitor the initiation of an antibiotic and conduct and ATO within 48-72 hours to monitor the response to the antibiotic. The nurse would also review laboratory results and consult with the physician to determine if the antibiotic was to continue or if any adjustments needed to be made. There was no indication the policy had been reviewed or revised annually to ensure it met current standards of practice.			F0881			07/24/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/02/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. John Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			06/26/2026

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: *The original building was built in 1961 and determined to be of Type II(000) construction; *The 1972 Addition was determined to be of Type II(000) construction; *The 1987 Addition was determined to be of Type II (222) construction; *The 1991 Addition was determined to be of Type II (222) construction, with a portion of the Addition being of Type V(111) construction; *The 2000 Addition was determined to be of Type III (211) construction. The facility has a capacity of 65 beds and had a census of 51 at the time of the survey.			K0000			06/26/2026

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K0000 Bldg. 01	Continued from page 2			K0000			06/26/2026
K0346 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2026 at 8:40 AM, it was revealed by review of available documentation that the fire alarm system out-of-service policy was incomplete and did not list the appropriate contact information to follow. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0346	The Administrator, Director of Nursing and Plant Operations Director reviewed the policy, and policy is updated as of June 26, 2026. Appropriate contact information for the fire marshal, fire department, alarm monitoring company, service provider and facility leadership has been added to the policy. Staff will be educated on the revised Fire Alarm System Out-of-Service Policy by July 15, 2026. The Plant Operation Director or designee will audit the policy annually and whenever updates to contact information occur to ensure continued compliances. Documentation of all fire alarm impairments and required notifications will be maintained. Responsible Person: Administrator, Director of Nursing, Plant Operations Director		07/15/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			K0353	On July 8th, during the scheduled testing and inspection, Brothers Fire will evaluate the sprinkler head in the kitchen freezer and replace the piping and sprinkler heads with a style that is designed and approved for cold storage environments. At the same time, while the sprinkler system is being serviced, the sprinkler head in the laundry chute room will also be replaced to ensure compliance and proper operation.		07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/02/2026	
NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH COUNTY ROAD 5 , SPRINGFIELD, Minnesota, 56087			
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K0353 SS = F Bldg. 01	Continued from page 3 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.2.1.1.2(2),(5), and 5.2.2.2. These deficient finding could have a widespread impact on residents within the facility. Findings include: 1. On 06/02/2026 at 9:21 AM, it was revealed by a review of available documentation that the facility could not provide documentation showing the sprinkler system had been inspected within the last year. 2. On 06/02/2026 at 9:22 AM, it was revealed by a review of available documentation that the facility could not provide documentation showing the sprinkler system had quarterly inspections completed during the 3rd and 4th quarter of 2025. 3. On 06/02/2026 at 10:29 AM, it was revealed by observation that the sprinkler head in the laundry chute in the soiled utility room 185 was heavily corroded. 4. On 06/02/2026 at 10:38 AM, it was revealed by observation that the sprinkler heads in the kitchen freezer had ice built up on them. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.			K0353			07/31/2026
K0354 SS = F Bldg. 01	Sprinkler System - Out of Service CFR(s): NFPA 101			K0354	The Administrator, Director of Nursing and Plant Operations Director reviewed the policy, and policy is updated as of June 26, 2026. Appropriate contact information for the fire marshal, fire department,		07/15/2026

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K0354 SS = F Bldg. 01	Continued from page 4 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2026 at 8:40 AM, it was revealed by review of available documentation that the sprinkler system out-of-service policy was incomplete and did not list the appropriate contact information to follow. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0354	Continued from page 4 alarm monitoring company, service provider and facility leadership has been added to the policy. Staff will be educated on the revised Sprinkler System Out-Of -Service Policy by July 15, 2026. The Plant Operations Director or designee will audit the policy annually and whenever updates to contact information occur to ensure continued compliances. Documentation of all sprinkler system impairments and required notifications will be maintained. Responsible Person: Administrator, Director of Nursing, Plant Operations Director		07/15/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain fire			K0521	The Plant Operations Director has contacted Schwikert's Tecta America to conduct the required damper inspections. The inspection has been scheduled and will be completed no later than July 31, 2026. Any deficiencies identified during the inspection will be corrected in accordance with the recommendations provided by inspector. To ensure ongoing compliance, the Plant Operations Director will maintain documentation of all fire damper inspections and establish a tracking system to ensure inspections are completed within the		07/31/2026

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K0521 SS = F Bldg. 01	Continued from page 5 dampers per NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives. sections 19.4 and 19.5 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2026 at 9:33 AM, it was revealed by a review of available documentation and staff interview that the fire dampers had not been inspected in the last 4 years. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0521	Continued from page 5 required 4-year inspection interval. Responsible person: Plant Operations Director		07/31/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2026 at 9:27 AM, it was revealed by a review of available documentation that the fire doors			K0761	A preventative maintenance schedule has been established within the facility's maintenance program to ensure annual fire door inspections and testing are completed on time. Documentation of inspections, testing, repairs, and corrective actions will be maintained. The Plant Operations Director or designee will monitor compliance by reviewing inspection records annually and maintaining a tracking log of required Life Safety inspections. Compliance will be reviewed during QAPI quarterly to ensure inspections remain current and documentation is complete.		07/31/2026

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K0761 SS = F Bldg. 01	Continued from page 6 had not been inspected within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0761			07/31/2026
K0741 SS = D Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and staff interview, the facility failed to enforce smoking policies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.4. This deficient finding could have an isolated impact on the occupants within the facility. Findings include: On 06/02/2026 at 11:20 AM, it was revealed by observation that there were two employees smoking in a non-designated smoking area.			K0741	On June 12, 2026, Plant Operations installed a standing smoking receptacle and wall-mounted ashtray at the identified location to establish a designated smoking area. The facility smoking policy was revised to clearly identify approved smoking locations for employees and visited. Updated policy will be communicated to staff by July 15th, 2026. All employees will be educated on the revised smoking policy and the requirement to use only designated smoking areas. The Administrator and Plant Operations Director will conduct routine monitoring of designated smoking areas to ensure ongoing compliance with smoking policy. Any identified concerns will be addressed immediately. Responsible Person: Plant Operations Director or designee		07/31/2026

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K0741 SS = D Bldg. 01	Continued from page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0741			07/31/2026