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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6XF5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 31639

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245635**

2.STATE VENDOR OR MEDICAID NO.
(L2) **681450100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS ON FOUNTAIN LAKE**
(L4) **1771 EAGLE VIEW CIRCLE**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 07/28/2021 (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **84** (L18)

13.Total Certified Beds **84** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 08/05/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/06/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/29/2018
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 5, 2021

CMS Certification Number (CCN): 245635

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 2, 2021 the above facility is certified for:

84 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 84 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 5, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: June 1, 2021

Dear Administrator:

On June 23, 2021, we notified you a remedy was imposed. On July 28, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 2, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 8, 2021 be discontinued as of August 2, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 23, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 8, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6XF5

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(L3) **ST JOHNS ON FOUNTAIN LAKE**
(L4) **1771 EAGLE VIEW CIRCLE**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/01/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	84			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 07/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/04/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/29/2018
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
June 23, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: June 1, 2021

Dear Administrator:

On June 1, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F812 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 8, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 8, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 8, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 1, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 1, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

(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
E 000	Initial Comments On 5/24/21 to 6/1/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 5/24/21 to 6/1/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F812 when: the facility failed to store, prepare and distribute food in accordance with professional standards for food service safety.. The IJ began on 5/28/21, and the immediacy was removed on 5/30/21.. The following complaint was found to be SUBSTANTIATED:. H5635015C (MN67200) with a deficiency cited at F660 and F661. The following complaints were found to be UNSUBSTANTIATED: H5635014C (MN65128) H5635016C (MN69137) H5635017C (MN69193) H5635018C (MN69256)	F 000		

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

Electronically Signed | 07/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		7/1/21

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	245635	A. BUILDING _____ B. WING _____	C 06/01/2021

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ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 609	Continued From page 2 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported to the State Agency (SA) timely, in accordance with established policies and procedures, for 1 of 2 residents (R47) reviewed for allegations of abuse. Findings include: R47's Record of Admission printed 5/26/21, included diagnosis of major depressive disorder, overactive bladder, chronic obstructive pulmonary disease, and polyarthritis. R47's quarterly Minimum Data Set (MDS) assessment dated 4/30/21, indicated R47 had a brief interview for mental status (BIMS) score of 14 (indicating intact cognition), was able to express her wants and needs and had no behaviors. The MDS also indicated R47 required extensive assistance of one person with activities of daily living (ADL's). R47 is frequently incontinent. R47's care plan, dated 9/3/20, indicated R47 has impaired physical mobility, likes staff to work slower with her and requires assist of 1 to sit up and lay down in bed, ambulate, dress, bathe and with personal hygiene. R47 has an alteration in elimination and requires assistance with toileting needs and bladder incontinence, and requires	F 609	FF609 1. The resident (R-47) was interviewed at the time of survey. An OHFC report was filed and investigation started. The five-day report was filed. 2. Other residents that reside in this household, and staff that work in this household, were interviewed. 3. Facility staff were re-educated on the Vulnerable Adult Policy beginning on July 1 and ongoing. The facility administrator will review all five-day reports. 4. Vulnerable Adult Reports are brought to the QAPI Committee for review. Five staff audits will be performed per week for six weeks. The results of the staff audits will be reviewed by the QAPI Committee. 5. Completion date July 1, 2021 and ongoing.	

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F 609	Continued From page 3 assist of 1 for transfers to toilet. During interview on 5/24/21, at 6:14 p.m., R47 stated "the girls are rough with me." R47 indicated she has told them they are too rough and they just ignore her. R47 indicated at times when they have gotten her dressed, she has had bruises and there are a lot of good ladies but some are just in too much of a hurry and are rough. R47 was unable to identify a date or time of occurrence or general time frame or identify the staff involved. During interview on 5/25/21, at 9:38 a.m., R47 was sitting up in chair. R47 denied staff being rough with her and said she likes the staff working today. During interview on 5/25/21, at 3:42 p.m., R47 stated feeling anxious this afternoon. Staff have been okay with her and no one has been rough with her. During interview on 5/26/21, at 9:17 a.m., R47 indicated staff last evening were rough with her when assisting her to the bathroom and sitting her down on the toilet. R47 indicated she could have bruises from the way they handled her but she doesn't know for sure, but they were rough on her arms. During interview on 5/26/21, at 9:29 a.m., nursing assistant (NA)-E indicated R47 has never said anything to her about staff being rough with her and did not mention anything about staff being rough with her last evening. NA-E indicated she got R47 up for the day and assisted her with toileting and dressing and did not see any bruising on her arms.	F 609		

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During interview on 05/26/21, at 9:41 a.m., NA-D indicated R47 has never told her anyone has been rough with her nor has she witnessed any rough care or treatment.

During interview on 5/26/21, at 9:57 a.m., registered nurse (RN)-A indicated R47 has never told her staff have been rough with her. RN-A was informed R47 stated the girls on the last evening shift were rough with her and wouldn't be surprised if she had bruising on her arms. RN-A indicated she knew the evening NA staff and could not think of any that would be rough with R47 on purpose.

During observation on 5/26/21, at 10:01 a.m., NA-D and NA-E assisted R47 from chair to bed. NA-D and NA-E used a gait belt, never held R47's arms, and assisted her to bed and to lie down, properly positioning R47 using the draw sheet.

During interview on 5/26/21, at 10:15 a.m., NA-A indicated R47 has never reported rough treatment to her and she has never observed rough treatment. NA-A indicated a few months ago, the social worker spoke to the nursing staff about taking time and not being hurried or rough with R47.

During interview on 5/26/21, at 10:50 a.m. - social worker (SS)-A indicated she started working at facility 2 weeks ago so is unsure of any events in the past, but since SS-A has been here, R47 has not reported any rough treatment to her.

During interview on 5/26/21, at 10:55 a.m., NM-A indicated she was notified in daily report meeting

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at 10:00 a.m., that R47 had reported rough treatment. NM-A indicated her plan is to talk to staff and let them know to slow down and take their time with R47. NM-A indicated sometimes when staff go too fast they pull too hard it and it comes across as rough treatment.

During interview on 5/26/21, at 12:45 p.m., SS-B, director of social services indicated at the end of April, she completed an assessment with R47 when she mentioned staff were rough with her. SS-B indicated she questioned R47 further who indicated it was only one staff member and she asked her to be more gentle with her next time. SS-B indicated R47 denied abuse and could not identify time or person who was rough with her so no report was completed. SS-B stated she told R47 she was very concerned she was being neglected or abused and R47 denied that.

During interview on 5/26/21, at 1:51 p.m., the director of nursing (DON) indicated she was not aware of R47 reporting rough treatment. The DON indicated any of the nursing staff should initiate conversation right away and gather more details regarding the situation and report if it is determined to be abuse for example "she grabbed my arm."

During interview on 5/26/21, at 1:58 p.m., R47 again indicated the staff were rough with her last evening and said they were mean to her. When asked if anyone had assessed her arms for bruising, R47 stated no, but she wouldn't be surprised if she had bruises, but then stated she didn't think she has any. R47 stated no one has talked to her about last evening. R47 indicated she is not afraid of any of the staff and thinks they need to slow down but they are mean and rough

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sometimes. R47 denied the treatment was abuse.

A progress note dated 5/26/21, at 11:00 a.m., (late entry at 5:06 p.m.) by NM-A indicated R47 was reviewed during interdisciplinary meeting as SS-A mentioned it was reported to her staff had been rough with R47. Will follow-up on staff "roughness".

A progress note dated 5/26/21, at 2:03 p.m. by RN-A indicated it was reported to her that on evening or night shift, staff were rough with R47 at times. RN-A immediately spoke with R47 and asked her if she felt safe here and if she was ok with the staff that was caring for her. R47 said she feels nervous and doesn't feel good lately, then started chanting "I need to take my pants off" multiple times. Staff changed her pants, offered her a snack and then R47 called her family.

A progress note dated 5/26/21, at 2:11 p.m., by RN-A indicated she asked R47 if she felt safe with staff or if she felt she had been harmed or handled rough and R47 said no.

During interview on 5/26/21, at 2:12 p.m., NA-F indicated she worked last evening with R47, who was very lonely. NA-F indicated she never stated she or the other NA working was rough with her. NA-F indicated R47 wanted staff to sit with her, but were unable to as they had other residents to care for. NA-F indicated they use 1-2 staff but try mostly to use 2 staff and a gait belt. NA-F indicated she never used R47's arms when standing her and used the draw sheet for positioning in bed.

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During interview on 5/26/21, at 2:18 p.m., NA-B indicated she got R47 ready for bed last evening and used the gait belt for transfers. NA-B stated she never uses R47's arms for transferring and R47 is able to stand up on her own. NA-B indicated R47 never said anything about hurried, rough or mean treatment and was thanking her and telling her she loved her.

A progress note dated 5/26/21, at 2:35 p.m. (late entry at 5:13 p.m.) indicated NM-A spoke with R47 who was anxious and feeling sad stating "I am mean to myself". When questioned if R47 is hurt anywhere she replied no. When asked if she is feeling ill, R47 replied "no". The discussion was then about the sunshine and R47 wanting to go outside. NM-A did assess R47's arms and no noted signs and symptoms of injury was present.

A progress note dated 5/26/21, at 3:30 p.m., the DON indicated at 2:00 p.m. she was informed R47 stated "the staff were so rough with me last night, I wouldn't be surprised if I had bruises." Vulnerable Adult team met and state report was filed at 3:14 p.m. with investigation ongoing.

During interview on 5/27/21, at 11:37 a.m., NM-A indicated she spoke with R47 who was very anxious but denied being injured or scared. R47 had short sleeves on and NM-A indicated she didn't see any signs of injury. NM-A indicated she thinks staff are moving to fast and R47 doesn't like that. NM-A indicated she did not directly ask R47 about the staff being mean, rough or abusive. NM-A indicated R47 changed the subject whenever NM-A would bring up a possibly injury. NM-A indicated she does not think abuse occurred, but is planning on educating staff on slowing down and using more patience and

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F 609	Continued From page 8 gentler techniques. During interview on 5/27/21, at 11:44 a.m., the DON indicated the event was reported 5/26/21, at approximately 3:12 p.m. after notifying the administrator of the event. The DON indicated she has interviewed the evening staff from 5/25/21, and multiple residents for potential rough or mean treatment and the investigation is ongoing. A facility policy titled Reportable Incidents Policy revised 1/7/21 included: - Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, as reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility (or their designee) and to the State Survey Agency. - Immediately means as soon as possible after discovery of the incident.	F 609		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable	F 660		6/30/21

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readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined

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F 660	Continued From page 10 to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and implement interventions to ensure a safe post-discharge plan for 1 of 1 resident (R111) reviewed who discharged to potentially unsafe living conditions. Findings include: Review of a vulnerable adult (VA) report dated 11/2/20, identified an allegation of improper	F 660	F660 1. Resident (R-111) no longer resides at the facility. 2. Residents that discharge to another setting could potentially be impacted by the deficient practice. 3. The Nurse Manager and Social Services are responsible for completing the Discharge Plan. Therapy staff will review the discharge	

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F 660	Continued From page 11 discharge planning concerning R2's discharge. The VA report indicated R111 notified a home health care (HHC) agency on 10/30/20, requesting assistance to shower. R111 indicated he did not have any services in place, to assist him with activities of daily living (ADL's). The VA report indicated R111 was discharged from the nursing home (NH) to the community, after receiving therapy services for a fractured hip. The VA report identified R111 as currently no weight bearing on the right hip and having a brace/halo on his neck/head, that is to remain on at all times. The VA report indicated R111 lives in an apartment on the 2nd floor, with 25 steps and no elevator. R111 was admitted to the facility on 9/9/20, with diagnosis (identified on the diagnosis report sheet in the medical record) dated 9/9/20, including: fracture of the left acetabulum (socket portion of the "ball-and-socket" hip joint), fracture of second cervical vertebra (bones located in neck), multiple fractures of the ribs, fracture of the left pubis (bones making up the pelvis), obesity, osteoarthritis, history of falling, chronic obstructive pulmonary disease (COPD) and anxiety disorder. R111 was discharged to the community on 10/23/20. R111's admission Minimum Data Set (MDS) assessment dated 9/15/20, identified R111 as having a baseline interview of mental status (BIMS) of "15" (meaning no cognition impairment). R111 requires extensive assistance with mobility and toileting and limited assistance with dressing, personal hygiene and bathing. The MDS identified R111 as having range of motion (ROM) impairment on the lower extremity of 1 side. R111 has an unsteady balance and gait.	F 660	plan with the resident prior to the discharge. The Physician or Provider will review the discharge plan with the Nurse Manager and Social worker after which the Provider will meet with the resident prior to the discharge to confirm plan. 4. A discharge checklist has been created to assure that the discharge is a smooth transition for the resident and will be completed with every discharge. The discharge process and checklist has been reviewed by the Social Worker, Nurse Manager, and DON. The Director of Nursing will audit all discharge plans for two months and perform random audits thereafter for four months. Results of the audits will be reviewed by the Quality Assurance Committee. 5. Completion date June 30, 2021 and ongoing.	

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R111 utilizes a walker and has had 1 fall with a fracture in the past 6 months. The MDS indicated R111 participated in his discharge goals and a plan to discharge to the community. The MDS indicated R111 and the care plan team decided a referral was not needed.

R111's discharge MDS dated 10/23/20, identified R111 as having a BIMS of "15" (meaning no cognition impairment). R111 requires limited assistance with mobility when walking in the corridor and extensive assistance with locomotion off the unit. R111 is independent with ADL's, except for requiring assistance with bathing. Limited assistance with toileting, dressing, personal hygiene and bathing. The MDS identified R111 as having range of motion (ROM) impairment of the lower extremity on 1 side. R111 utilizes a walker. The MDS indicated R111 participated in the discharge goals and plans, and plans to discharge to the community. The MDS indicated R111 and the care plan team decided a referral was not needed.

R111's care plan dated 9/24/20, identified R111 as having alteration in thought process related to depression and anxiety disorder. R111 has impaired mobility related to a fractured left hip, pubis, cervical vertebrae and rib fractures. R111 also has a history of falling. Interventions include; assistance with turning and repositioning in bed, assistance with transfers, assist with ambulation in room with transfer belt and walker (toe touch weight bearing to left lower extremity). physical therapy (PT) and occupational therapy (OT) 5 times weekly for strengthening. R11 requires assistance with bathing, grooming and dressing related to the above diagnosis. R11 is identified as being vulnerable related to physical

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impairment. The care plan further indicated R111 plans to return to the community with assistance of his daughter. Requires assistance to find an apartment with no stairs. The care plan indicated R111 requested referral information about returning to the community. Interventions included; the interdisciplinary team will assess for appropriate placement following completion of rehab program, make recommendations for supportive services, social services will assist with community resources and provide information and encourage a leave of absence (LOA),

Review of the OT discharge summary notes dated 10/23/20, indicated R111 received services from 9/9/20 to 10/22/20. The discharge progress notes indicated R111 was able to complete all goals except, requiring verbal instructions and cues for safety with shower transfers. The note indicated the goal had not been met related to unexpected discharge. The discharge plan and instructions were to continue skilled OT in home with home health care (HHC) assistance, assistance with showers, recommend a shower chair, assist with grocery delivery, reacher, sock aide, long handled shoe horn and walker tray/basket.

Review of the PT discharge summary notes dated 10/23/20, indicated R111 received services from 9/10/20 to 10/23/20. The discharge progress notes indicated R111 met all of his goals but remains toe touch weight bearing to left leg. The progress note indicated R 111 will be returning to his apartment today and will have HHC services. The resident will be obtaining a four wheeled walker and reacher for home use.

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R111's progress notes were reviewed;

-On 10/17/20 to 10/22/20, entry notes by nursing staff indicated R111 had been independent with ADL's, with the use of assistive devices (did not include what type of devices).

-On 10/21/20, at 12:11 p.m., entry note by registered nurse (RN)-G, indicated R111's insurance coverage was ending on 10/22/20. The insurance company determined further care would be custodial. R111 was given the option to appeal the decision, but declined.

On 10/21/20, at 3:30 p.m. entry note by licensed social worker (LSW)-D indicated R111 informed her that his last covered therapy day would be on 10/22/20, and R111 would need to discharge back home on 10/23/20. R111 told LSW-D he was worried about how he would be able to get into his apartment, because it was on the second floor with 25 steps. LSW-D also indicated R111 was still in need of assistance with some ADL's. LSW-D stated she would give R111 a list of HCC agencies before he discharged from the facility. R111 was upset that his insurance would no longer cover his stay, because his hip was not healed and continues to require therapy.

-On 10/22/20, at 5:45 a.m. entry note by licensed practical nurse (LPN)-H, indicated R111 stated he had a hard time sleeping during the night. R111 stated he was worried about his insurance coverage ending on 10/22/20. R111 indicated he did not know what he was going to do after receiving the notice.

-On 10/22/20, at 1:28 p.m. entry note by LSW-D indicated R111 told her the provider wrote an

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order for an electric chair lift for his apartment and HCC services, and felt less anxious about going home. LSW-D indicated she gave R111 a list of resources for HCC agencies that he would need to contact. LSW-D was unsure what agencies would take medical assistance (MA).

-On 10/22/20, at 3:38 p.m. entry note by health unit coordinator (HUC)-A indicated R111 received orders from the provider indicating R111 was toe touch weight bearing to the left leg and had a diagnosis of a left pubic vamus fracture. R111 was cleared to discharge to home with medications

-On 10/23/20, at 5:47 a.m. entry note by LPN-G indicated R111 slept poor during the night.

-On 10/23/20, at 1:39 p.m. entry note by RN-H indicated R111 discharged to home at 12:30 p.m. with his daughter. Discharge papers and medications were sent with R111.

The discharge care plan for R111 dated 10/23/20, completed by LSW-E was reviewed. The discharge note indicated R111 will need HCC services when returning home. R111's insurance company will assist the resident with service. The note indicated R111 is self care and potentially may have HHC services. No outpatient therapy was ordered. This care plan was reviewed and given to R111 upon discharge.

Review of a physicians orders for R111 dated 10/22/20, at 3:00 p.m. identified R111 as utilizing a wheeled walker for ambulation and remains toe touch weight bearing on the left leg. The physicians orders included orders to discharge R111 to home with medications .

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The discharge plan and instructions were to continue skilled OT in home with home health care (HHC) assistance, assistance with showers, recommend a shower chair, assist with grocery delivery, reacher, sock aide, long handled shoe horn, walker tray/basket, wheeled walker and reacher

There was no documentation in R111's medical record that indicated R111 was assisted with resources that included HCC services., even though the staff were aware of R111's ADL's needs and at home living condition. Also, there was no documentation related to the adaptive devices that PT/OT recommended upon discharge as well as providing outpatient OT services.

Interview on 5/26/21, at 10:30 a.m. the complainant indicated R111 phoned the HCC agency shortly after discharging from the facility, inquiring about their services. The complainant indicated after the call, the HCC agency conducted a home visit with R111. The complainant indicated R111 lived on the second floor with 25 steps leading up to his apartment. R111 had been scooting up and down the stairs on his buttocks. The complainant indicated R111 was not clean and required assistance with showering.

Interview on 5/26/21 at 11:00 a.m. R111's daughter stated the facility had not provided referrals for HCC services upon R111's discharge. R111's daughter also stated the only information that was given to them upon discharge, was the list of ordered medications. R111's daughter confirmed she had transported

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R111 home from the facility and was aware of the steps leading up to the apartment. R111's daughter further added because of family circumstances, she did not know what she could do to assist R111.

Interview on 5/26/21 at 1:00 p.m. LSW-E stated she had been a part of R111 discharge plan for only a few days, leading up to his discharge. LSW-E indicated LSW-D had been working with R111 and his discharge plan. LSW-E further included LSW-D was no longer working at the facility and was unsure of the specifics of what had been done. LSW-E verified she had been the LSW that discharged R11 on 10/23/20 and failed to follow through the recommendations provided by therapy. The recommendations included adaptive devices and out patient therapy services as well as confirmation of HCC services.. LSW-E stated she thought R111 had called a HCC agency and had an appointment with them the following week. LSW-E stated she recalled LSW-D making attempts to call several HCC agencies, but they would not cover certain aspects of care. LSW-E also indicated she thought R111 was going to be staying at his daughters, until he was able to utilize steps.

Interview on 5/27/21, at 11:00 a.m. the facility director of physical therapy (PT) and occupational therapy (OT) indicated R111 was discharged from therapy services related to R111's declining further insurance coverage and not wanting to privately pay. The therapy director indicated R111 was discharged from services with the expectation R111 would receive HHC services and outpatient OT services after discharge. The therapy director confirmed R111 remained only toe touch weight bearing on the left

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F 660	Continued From page 18 leg, and adaptive devices had been recommended from OT for R111 to utilize with cares at home. Interview on 6/1/21, at 11:00 a.m. the interim director of nursing (DON) confirmed the facility failed to implement recommendations and interventions to ensure a safe post discharge plan for R111. The interim DON stated she thought the facility SW took care of the discharge planning for R111. Review of the facility policy Discharge Planning dated 8/19, directed the unit Social Worker (SW) to have joint discussions and decision making regarding appropriateness/inappropriateness of a transfer or discharge, the nursing staff will confer with the SW regarding any problems or concerns with the resident, other departments (therapy services) will be involved when appropriate, if concerns or issues arise and the SW and nursing department are unable to resolve, then the administrator will be refereed to find a resolution. The policy directed staff to follow the discharge to home policy and procedure. Review of the facility policy Discharge to Home Procedure dated 8/19, directed the interdisciplinary team to discuss a planned date for resident discharge, inquire if there is need for (outpatient therapies, assistive devices, home care services), and request orders from the provider, schedule follow up appointments, review the discharge plan of care with the resident or guardian and complete a discharge summary by the discharging staff.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)	F 661		6/30/21

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F 661	Continued From page 19 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate discharge instructions were provided and documented to ensure continuity of care and reduce the risk of post-discharge complications for 1 of 1 resident (R111) reviewed for admission, transfer and discharge practices.	F 661	F661 1. Resident (R-111) no longer resides at the facility. 2. Residents that discharge to another setting could potentially be impacted by the deficient practice. 3. The Nurse Manager and Social	

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F 661	Continued From page 20 Findings include R111 was admitted to the facility on 9/9/20, with diagnosis (identified on the diagnosis report sheet in the medical record) dated 9/9/20, including: fracture of the left acetabulum (socket portion of the "ball-and-socket" hip joint), fracture of second cervical vertebra (bones located in neck), multiple fractures of the ribs, fracture of the left pubis (bones making up the pelvis), obesity, osteoarthritis, history of falling, chronic obstructive pulmonary disease (COPD) and anxiety disorder. R111's Discharge Summary identified that R10 was discharged from the facility on 12/18/21. The discharge summary was signed by the nurse on 12/19/2021, which was after R10 discharged from the facility on 12/18/21. The summary lacked a recapitulation of R10's stay and on the line for physician signature was left blank. R111's discharge care plan dated 10/23/20, completed by LSW-E was reviewed. The discharge note indicated R111 will need HCC services when returning home. R111's insurance company will assist the resident with service. The note indicated R111 is self care and potentially may have HHC services. No outpatient therapy was ordered. This care plan was reviewed and given to R111 upon discharge. Review of a progress note dated 10/23/20, at 1:39 p.m. indicated R111 discharged to home at 12:30 p.m. with his daughter. Discharge papers and medications were sent with R111. R111's medical record did not include a Discharge Summary that included a recapitulation	F 661	Services are responsible for completing a Discharge Plan. Therapy staff will review the discharge plan with the resident prior to the discharge. The Physician or Provider will review the discharge plan with the Nurse Manager and Social worker after which the Provider will meet with the resident prior to the discharge to confirm plan. 4. A discharge checklist has been created to assure that the discharge is a smooth transition for the resident and will be completed with every discharge. The discharge process and checklist has been reviewed by the Social Worker, Nurse Manager, and DON. DON, Administrator, Nurse Managers and Social Services will meet to review the discharge planning and policy. The Director of Nursing will audit all discharge plans for two months and perform random audits thereafter for four months. Results of the audits will be reviewed by the Quality Assurance Committee. 5. Completion date June 30, 2021 and ongoing.	

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F 661	Continued From page 21 of R111's stay. Interview on 5/26/21 at 1:00 p.m. LSW-E stated she had been a part of R111 discharge plan for only a few days, leading up to his discharge. LSW-E indicated LSW-D had been working with R111 and his discharge plan. LSW-E further included LSW-D was no longer working at the facility and was unsure of the specifics of what had been done. LSW-E verified she had been the LSW that discharged R111 on 10/23/20 and failed to complete a Discharge Summary that included a recapitulation of R111's stay. Interview on 6/1/21, at 11:00 a.m. the interim director of nursing (DON) confirmed the facility failed to implement recommendations and interventions to ensure a safe post discharge plan for R111. The interim DON stated she thought the facility SW took care of the discharge planning for R111. Review of the facility policy Discharge to Home Procedure dated 8/19, directed the interdisciplinary team to discuss a planned date for resident discharge, inquire if there is need for (outpatient therapies, assistive devices, home care services), and request orders from the provider, schedule follow up appointments, review the discharge plan of care with the resident or guardian and complete a discharge summary by the discharging staff.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		6/30/21

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F 677	Continued From page 22 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care and grooming for 1 of 2 resident (R27) reviewed for activities of daily living (ADL) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R27's face sheet printed on 5/24/21, identified diagnoses including multiple sclerosis and severe obesity. R27's quarterly Minimum Data Set (MDS) assessment dated 4/6/21, indicated R27 was cognitively intact, limited in range of motion of the left upper extremity and both sides of the lower extremities. R27 required extensive assistance for bed mobility, transfers, toilet use and total dependence with bathing, dressing, transfers, repositioning, and utilized a wheelchair. R27's care plan dated 4/14/21, identified R27 required two staff assist with bathing upper/lower body, bathes own hands/face. Assist of one to bathe upper/lower body/feet/back dry/lotion. Shampoo to scalp as ordered weekly. Observe and report skin problems and decline to nurse, trim nails. Personal hygiene: one assist comb hair/shave/apply makeup/peri- cares. Resident may be able to brush teeth, wash face and hands after supplies handed to him. R27's record review titled documentation record May 2021, indicated R27 received a bath every Monday evening with the last documented bath	F 677	F 677 1. Nail care and facial hair removal was completed at the time of survey for the resident, R27. 2. All residents could potentially be impacted by the deficient practice. 3. Skin checks are performed by St. John s nursing staff on bath days. Nursing staff will check nail care and facial hair on bath day and perform necessary grooming tasks on bath day. Nail care and facial care have been added to the skin check worksheet. Nursing staff will be re-educated on the importance of performing nail care and facial hair removal on bath days as evidenced by completion of nail/hair care audits. Nurse Managers will review policy on nail care and facial hair removal (grooming) and discuss its importance with nursing staff. 4. Random grooming audits will be performed by licensed nurses six times a week, per floor. Audits will be turned into Nurse Managers for review. Audits will be ongoing until 100% compliance is noted for a period of two weeks. After compliance has been determined, random audits will be performed eight times a month, per floor. Audits will be turned into the Nurse Managers for review. Audit results will be reported to the Quality	

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F 677	Continued From page 23 5/17/21. During observation on 5/24/21, at 6:40 p.m. R27 was in his room seated in his wheelchair and his daughter was present in the room. R27 was observed with long and jagged fingernails with brown debris under his nails on both hands. When asked, R27 stated he disliked the length of his fingernails and indicated his fingernails needed to be cut. R27's daughter discussed his nose hairs and hair in his ears were too long and she would expect the ear and nose hair trimmed. During interview on 5/26/21, at 12:55 p.m. nursing assistant (NA)-G verified R27's nails were long, jagged, and dirty. NA-B discussed nails were cut on bath days and she would have expected R27's nails to have been cut and cleaned at his last bath. During interview on 5/26/21, at 1:05 p.m. licensed practical nurse (LPN)-B discussed nail care was completed by the nursing assistants on bath days and would expect R27's nails to be cut and cleaned at the last bath. Interview on 5/26/21, 3:00 p.m. with the interim director of nursing (DON) discussed the nail care of residents and indicated she expected nail care and grooming of hair completed with resident's baths and showers. The DON further discussed, she expected staff to assess the resident's fingernails daily and provide nail care with long and jagged nails. The facility policy titled St. Johns Lutheran Community Standards of Care dated 12/18/18, included:	F 677	Assurance Committee. 5. Completion date June 30, 2021 and ongoing.	

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F 677	Continued From page 24 Purpose: To provide a foundation as to how a nurse/or CNA should care for residents in their care. Policy: Nurses are expected to be in compliance with these standards and to ensure their CNAs are also incompliance. Procedure: A complete tub bath or shower shall be provided at a minimum of once a week for all residents. A complete bath every week, and a partial bath daily, and more often as need it for residents confined to a bed. A minimum of monthly shampoos, and assistance with daily hair grooming as needed. Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Fingernails and toenails shall be cleaned and trimmed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		6/30/21

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F 688	Continued From page 25 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 1 of 2 residents (R53) reviewed for limited ROM. Findings include: R53 was admitted to the facility on 4/26/21, with diagnosis (identified on the diagnosis report sheet in the medical record) dated 4/26/21, that included: nondisplaced comminuted fracture of the right humerus (long bone in the upper arm between the elbow joint and the shoulder), Parkinson disease (disorder of the central nervous system), polyosteoarthritis (pain/inflamed joints) and osteoporosis (arthritis is the joints) R53's admission Minimum Data Set (MDS) assessment dated 5/2/21, identified R53 as having a brief interview for mental status (BIMS) of "14" (meaning no impairment in cognition). R53 required extensive assistance with activities of daily living (ADL's). The MDS further indicated R53 had ROM impairment on one side of the upper extremity. The MDS indicated R53 has diagnosis of arthritis, osteoarthritis and a non-displaced comminuted fracture of the right humerus. R53's care plan dated 5/24/21, identified R53 as having impairment of physical mobility related to a	F 688	F688 How will the deficiency be corrected for the residents impacted? Resident (R53) was discharged from the facility on June 26, 2021. How will the facility help identify who will be potentially affected? Residents with a Range of Motion decline could potentially be impacted by the deficient practice. What measures will be put into place to insure it will not happen again? RN□s and Therapists will be re-educated on the need to address Range of Motion and Contracture deficits during the seven day admission assessment. Facility will insure that a resident with a range of motion deficit or contracture have an action plan in their care plan. Therapy assessments and evaluations will be reviewed at the weekly IDT meeting. Range of Motion/contracture declines will be reviewed at weekly IDT Meetings and referred to therapy for an evaluation/assessment when indicated. How will the facility monitor corrective action? The Director of Nursing will perform	

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F 688	Continued From page 26 fracture of the right humerus, Parkinson disease, osteoarthritis, polyosteoarthritis and weakness. Interventions included; physical therapy (PT) and OT. The care plan identified R53 as having alteration in dressing, grooming and bathing related to above diagnosis. Interventions included; OT, assistance with dressing and application of right arm sling, monitor for pain and report any decline to the licensed nurse. The care plan did not include R53's limited ROM in the right hand and fingers. Observation and interview on 5/24/21, at 4:00 p.m. R53 was observed to have a sling on his right arm. R53's 3rd, 4th and 5th fingers noted to be bent inward towards the palm. When asked if he could open his right hand/fingers, the resident was unable. R53 did not have a splint or any adaptive device in place to prevent contractures. R53 indicated he has not been able to open his fingers fully for at least a couple of months. R53 further indicated he had a sling on his right arm, because he had fallen and fractured his arm. Observation and interview on 5/26/21, at 9:30 a.m. R53 was in his room receiving occupational therapy (OT) treatment to the right arm, by certified occupational therapy assistant (COTA)-A. Interview with COTA-A at this time, indicated she had been aware of R53's limited ROM in the right hand/fingers. COTA-A stated while providing ROM treatment to R53's right shoulder, she will at times include the right hand. COTA-A confirmed R53 currently did not have orders for ROM services to the right hand/fingers, nor did the resident have any type of adaptive device to prevent further decline in ROM. COTA-A attempted to open R53's fingers of the right hand, but was unable to move the 3rd, 4th	F 688	monthly audits and discuss findings at next QA meeting. At that time the committee will make additional audit recommendations. Date it will be completed Completion date June 30, 2021 and ongoing	

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F 688	Continued From page 27 and 5th fingers with manual assistance. Review of the PT plan of care and progress notes dated 4/27/21, (treatment start date) to 5/26/21 (current) did not identify or include R53's impairment of ROM in the right hand/fingers. Although R53 had been receiving therapy services to the right arm 5 times weekly, the staff failed to implement interventions to maintain and prevent further decline in ROM to the right hand/fingers when identified. Review of the OT plan of care and progress notes dated 4/27/2 (treatment start date) to 5/26/21 (current) did not identify or include R53's impairment of ROM in the right hand/fingers. Although R53 had been receiving therapy services to the right arm 5 times weekly, the staff failed to implement interventions to prevent further decline in ROM to the right hand/fingers when identified. R53's current physicians orders dated 5/1/21, did not include ROM orders or adaptive devices to prevent contractures in R53's right hand/fingers. Review of the progress notes from 4/26/21 (admission date) to 5/26/21 (current) did not include R53's limited ROM in the right hand/fingers. Interview on 5/26/21, at 9:00 a.m. nursing assistant (NA)- G indicated R53's 3rd, 4th and 5th fingers of the right hand had been bent tightly since admission. NA-G further indicated there was no current treatment implemented for R53's right hand/fingers to prevent contractures or further impairment in ROM.	F 688		

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F 688	Continued From page 28 Interview on 5/27/21, at 9:00 a.m. the facility OT/PT director confirmed therapy staff had been aware of R53's limited ROM in the fingers of the right hand. The facility OT/PT director stated the staff should have reported and documented R53's limited ROM when identified on admission. The facility OT/PT director further confirmed there were no interventions implemented prevent further decline. Interview on 5/27/21, at 2:00 p.m. the interim director of nursing (DON) indicated she had not been aware of R53's limited ROM in the right hand/fingers. The interim DON stated she would have expected OT and the nursing staff to have reported the findings when identified. A policy was requested but not provided.	F 688		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		6/30/21

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F 758	Continued From page 29 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) of a psychotropic medication was attempted or rationale provided for current dose justification for 1 of 5 residents (R11) reviewed for unnecessary medication use. Findings include:	F 758	F758 1. The physician reviewed and addressed the resident□s (R11) psychotropic medication usage on June 30, 2021. 2. All residents that are prescribed psychotropic medications have the	

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F 758	Continued From page 30 R11's Record of Admission printed 5/26/21, indicated diagnosis including chronic pain disorder, anxiety, insomnia, and major depressive disorder. R11's quarterly Minimum Data Set (MDS) assessment dated 3/10/21, identified R11 was cognitively intact, exhibited no behaviors, and scored a 1/27 on Patient Health Questionnaire (PHQ)-9 (Major depressive disorder module used to diagnose depression) indicating minimal symptoms of depression. MDS also indicated R11 received 7 days of antidepressant. R11's Physician Orders dated 5/1/21, included Cymbalta 60 mg orally daily for depression/anxiety/chronic pain and Wellbutrin XL 150 mg orally daily for depression. R11's care plan dated 3/22/21, identified R11 has an altered mood related to primary diagnosis of chronic pain syndrome, falls with multiple injuries but has improved since his wife has been able to visit more. Interventions included assess for changes in mood, review 24 hour reports daily, review at weekly interdisciplinary meetings and report to social services mood changes such as withdrawal, tearfulness, sadness, decreased appetite and sleeping changes. R11's "Behavioral-Medication Monitoring sheet dated 10/9/20, included pharmacists recommendation that Wellbutrin has been in place at the current dose since initiated in 5/2019 with no trial reduction or trial off and Cymbalta has been in place at the current dose since 11/2017. Pharmacy Recommendation included; please advise if a trial reduction of any agents is	F 758	potential to be impacted by the deficient practice. 3. The Nurse Managers will monitor consulting pharmacist recommendations related to psychotropic medications. If the NM identifies that a provider did not address the recommendation, he/she will notify the Director of Nursing for immediate follow up. The consulting pharmacist□s recommendations will be reviewed by the nurse manager and given to the Health Unit Coordinator or HUC. The HUC will be responsible for giving the pharmacist□s recommendation to the physician or provider during their scheduled visits To avoid reoccurrence: Residents have scheduled visits with their Provider every 60 days and as needed. To insure that psychotropic drugs are being reviewed and addressed, the week prior to a scheduled Provider visit - the Health Unit Coordinator will notify the DON of upcoming appointments. The DON will request/verify that the consulting pharmacist will review any psychotropic meds prior to the visit making necessary recommendations available for the provider to address at the scheduled visit. 4. Post provider visit, the Nurse Manager will insure psychotropic recommendations were addressed. The consulting pharmacist will also notify the Director of Nursing in the event that a	

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F 758	Continued From page 31 appropriate at this time vs the clinical contraindication to reducing. The provider response dated 10/21/20 included pharmacy has suggested trial of dose reduction, however, he appears the best have ever seen him today. With current isolation during COVID epidemic, do not recommend trial of dose reduction at this time. R11's "Behavioral-Medication Monitoring" sheet dated 4/15/21, completed by the pharmacist indicated R11 was on Wellbutrin XL 150 mg and Cymbalta 60 mg as well as Melatonin 5 mg at bedtime. Pharmacist recommendation included; R11 is due for a trial dose reduction attempt at this time, unless clinically contraindicated to reduce. No reduction was attempted 10/9/20 upon the last review, noting he is doing quite well respective to his chronic depression. A Medication Record for 5/1/21 through 5/31/21 indicated Cymbalta 60 mg and Wellbutrin XL 150 mg were given orally daily through date of report 5/25/21. During interview on 5/27/21, at 9:36 a.m., nurse manager (NM)-A indicated no response has occurred from the provider for the April pharmacy recommendation. NM-A indicated the pharmacy recommendation was put in a file until the providers next visit but is unsure when that will be but thinks it is every 2 months. A policy titled "Psychotropic Medication Use Policy and Procedure" dated 9/19 included: - Psychotropic medications will only be used with proper documented need and consent. - A resident will not receive psychotropic medications without a documented need.	F 758	psychotropic medication recommendation was not addressed by the physician or provider. The Director of Nursing will perform monthly audits and discuss findings at next QA meeting, address findings at that time with the committee and the committee will make additional audit recommendations. Psychotropic usage will continue to be reviewed monthly by the consulting pharmacist and quarterly by the QAPI Committee. Additionally, the facility administrator, DON and Nurse Managers will meet on the first Monday of every month to verify psychotropic medication recommendations have been addressed. 5. Completion date June 30, 2021 and ongoing.	

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F 758	Continued From page 32 A policy titled "Drug Regimen Review Policy" undated included: - The licensed pharmacist will report in writing, any irregularities to the attending physician, the facility's medical director and the director of nursing to be acted upon. - The objective of this requirement is to try to minimize or prevent adverse consequences or to or prevent residents from receiving unnecessary drugs. - Irregularities identified will be documented on a separate, written report and sent to the attending physician, medical director and director of nursing, listing the resident name, relevant drug and irregularity the pharmacist has identified. - The attending physician will document in the resident record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If the physician chooses not to act upon the pharmacy consultant recommendations, the physician must document rationale as to why the change is not indicated in the resident record.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		7/1/21

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F 804	Continued From page 33	F 804	F804	

by:
Based on observation, interview and document review, the facility failed to ensure food was served in a manner that was palatable in 1 of 5 facility satellite kitchens (2B). This deficient practice had the potential to affect all 13 residents residing on unit 2B who consumed food from the kitchen.

Findings include:

R58's significant change Minimum Data Set (MDS) assessment dated 5/9/21, indicated R58 was cognitively intact; had adequate vision and hearing, clear speech, was understood and could understand others. R58 was independent with bed mobility, required no help from staff for transfers or walking in her room. R58 was independent with eating and required no staff assistance.

During dining observation and interviews on unit 2B on 5/24/21, at 4:35 p.m., homemaker (HM)-A was observed making grilled cheese sandwiches. HM-A stated she had been employed as a homemaker at the facility for about two weeks, adding she had five days of training with three different homemakers before starting on her own. In her position, she was responsible for preparing and serving meals to 13 residents currently residing on the second floor, unit 2B.

During observation and interview on 5/24/21, at 4:40 p.m., HM-A placed a shallow, rectangular pan in the oven with six sandwiches on it. The sandwiches consisted of two slices of white bread with cheese slices in the middle. HM-A stated the oven had been set at 350 degrees Fahrenheit (F). After a short period of time, HM-A removed the

F804
1. Dietary Manager will monitor food presentation to assure that food is palatable and appealing.

2. All residents have the potential to be impacted by the deficient practice.

3. Staff will be reeducated on serving palatable meals beginning on July 1, 2021 and ongoing.

A Resident Food Committee has been established to review menus and meal services provided by dietary staff. This committee will meet monthly with no end date. The Dietary Manager will be responsible for addressing food concerns brought up by the Food Committee.

Once a month, one Resident per floor will complete a meal audit. The results of the audit will be reviewed by the Resident Food Committee.

The facility has hired a Dietary Assistant to assist the Dietary Manager with dietary job responsibilities.

A dietary in-service, given by the consulting Registered Dietician, is scheduled for July 21, 2021. The purpose of this in-service is to reinforce the importance of serving palatable meals, and the importance of following proper dietary practices. At the end of this in-service, a competency quiz will be given to all dietary employees and each

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F 804	Continued From page 34 pan from oven and buttered the outside pieces of the bread, then returned the pan to the oven. When asked how long the sandwiches needed to bake, HM-A stated she kept them in the oven until they looked okay. At 5:23 p.m., HM-A started plating the grilled cheese sandwiches for residents eating in their room. The sandwiches were not a toasted or grilled color; they were white and the cheese was only slightly melted. During an observation on 5/24/21, at 5:36 p.m., (NA)-B brought a half grilled cheese sandwich back to the kitchenette from R58's room, requesting HM-A put it back in the oven to get toasted. During an observation on 5/24/21, at 5:49 p.m., HM-A handed a plated, whole, uncut sandwich to (NA)-C to take back to R58's room. The sandwich did not have the color of being toasted or grilled. During an interview on 5/24/21, at 6:03 p.m., R58 was sitting in her recliner with an over-bed table in front of her with a tray of food on top. R58 leaned over and removed half of a grilled cheese sandwich from a wastebasket next to her recliner, stating "feel how hard this is." Sandwich was firm and dry to the touch. The bread was white in color and did not have toasted or grilled coloring on it. R58 stated she asked for a different sandwich that wasn't so hard and stated "this is what I got." R58 pointed to a sandwich on her tray that included two thick pieces of white bread, which R58 stated were not soft; with two thick slices of cheese inside. The bread was white in color and did not have toasted or grilled coloring on it. The cheese was only slighted melted and the sandwich wasn't cut in half for easy handling and eating. R58 stated, "I still can't eat this; it's too	F 804	must pass with a score of 80% or greater. 4. A minimum of six audits will be completed by a staff member weekly (this will include audits of both lunch and dinner) for three months. This will be followed by three audits per week for an additional three months. One audit per month on one lunch and dinner meal ongoing. The dietary manager will report results of the audits to the administrator once a week. Food safety concerns will be verbally reported to the administrator immediately. The Registered Dietician will do a monthly in-services for the next six months to address issues identified during the audits, or brought to the facilities attention by the resident food committee. The Registered Dietician will perform one random audit per month for six months to assure ongoing compliance with food service guidelines. Dietary audit results will be reviewed at the quarterly QAPI meetings. 5. Date of completion July 1, 2021 and ongoing.	

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F 804	Continued From page 35	F 804		

hard." R58 did not eat the sandwich and instead ate yogurt, apple slices and milk. R58 did not want to ask for anything else to eat.

During an interview on 5/26/21, 8:13 a.m., dietary director (DD)-A stated HM-A started two weeks ago and trained with homemakers who had been at the facility for awhile. DD-A indicated training included how to pick up food from the main kitchen in the basement to take to their satellite kitchens and how to cook it. When informed of observations from the evening meal on 5/24/21, of grilled cheese sandwiches that were not toasted or grilled and served to residents, DD-A stated HM-A was probably not shown how to make sandwiches in the oven to become toasted. DD-A admitted that an untoasted sandwich with only slightly melted cheese, wasn't a grilled cheese sandwich and that it did not sound appealing to eat.

During an interview on 5/26/21, at 10:12 a.m., DD-A stated there was no orientation training checklist for HM-A who started working at the facility on 5/13/21. Neither HM-A nor two of her trainers (HM)-B and (HM)-C, recalled seeing one. DD-A stated, "to be honest, I don't think they are using the orientation checklists." DD-A admitted it was her responsibility as dietary director to ensure homemakers were trained properly before working on their own.

Facility policy titled Dietary Policies, dated October 2017, indicated:
Each resident received and the facility provided:
--Food prepared by methods that conserved nutritive value, flavor, and appearance. Food and drink were palatable, attractive, and served at a safe and appetizing temperature.

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F 804	Continued From page 36 --Food would have taste, aroma, and appearance that encouraged resident consumption of food. Facility policy titled Employee Education dated 3/1/21, indicated: --All employees were assigned online orientation education at hire and were to complete the education prior to job/floor training beginning.	F 804		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prepare food in accordance with resident needs and per physician orders for 3 of 58 resident (R11, R25, R35) who required therapeutic diets (mechanical soft texture) Findings: R35, R11, and R25 current Minimum Data Set (MDS) assessments identified residents were independent with eating, required eating set up, and no swallow disorders. R35's physician orders dated 11/16/20, identified mechanical soft diet order . R11's physician orders dated 10/24/18, identified mechanical soft diet order.	F 805	F805 1. Residents R35, R11, and R25 care plans have been updated. The appropriate therapeutic diet is being prepared and offered to these residents. 2. All resident□s diets were reviewed by Dietary Manager and facility RN□s to confirm the correct prescribed therapeutic diets are in place. Care plans have been updated to include therapeutic diets. Any future residents would have the potential to be impacted by the deficient practice. 3. The Dietary Manager has reviewed all resident diets and has developed a tray card system to communicate to staff: " Therapeutic diets □ Doctor prescribed (General, Diabetic, Cardiac, Renal, Gluten Free and Low Sodium).	7/1/21

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F 805	Continued From page 37 R25's physician orders dated 4/10/20, indicated mechanical soft diet order. Document titled, Week 1 Thursday (for 5/27/21) diet spreadsheet regular menu indicated: sweet and sassy pork burger on bun, potato chips, baked beans, seasonal fresh fruit, and milk and the renal diet indicated: pork burger/bun, hebed rice, frozen green beans, seasonal fresh fruit (no banana), cranberry, apple, or grape juice. The mechanical soft diet indicated; ground sweet and sassy pork burger on bun, cheese puffs, baked beans, banana or canned fruit, and milk. On 5/27/21, between 4:30 p.m. and 5:30 p.m. R35 received a regular texture pork burger, baked beans, potato chips, mixed fruit including whole grapes; current diet order indicated mechanical soft. R11 received a regular texture pork burger, baked beans, potato chips, mixed fruit including grapes; current diet order indicated mechanical soft. R25 received a regular texture pork burger, baked beans, potato chips, mixed fruit including grapes; current diet order indicated mechanical soft. On 5/26/21, at 3:00 p.m. during observation and interview, dietary manager (DM) was observed to locate the alternative therapeutic menus binder in the 3 B satellite kitchen. DM confirmed the dietary staff should follow therapeutic diets and further indicated the facility was short staffed and homemakers were not entirely trained regarding understanding the use of the therapeutic diets (example: mechanical soft texture diet). On 5/26/21, at 3:56 p.m. homemaker on floor 3B HM-F, stated she has worked at the facility for six months and has not offered therapeutic diets to	F 805	" Dietary restrictions □ Food allergies written in red. Fluid restrictions identified with an intake record " Dietary preferences Additionally, Dietary staff has implemented a Cook□s Corner during which homemakers interview residents to confirm diet, allergies, preferences (likes/dislikes) and place these in the Resident meal card binder for reference. Dietary staff will be educated on tray card system beginning on July 1, 2021 and ongoing. The facility has hired a Dietary Assistant to assist the Dietary Manager with dietary job responsibilities. 4. Random audits will be performed four days per week for three months and ongoing as needed. The dietary manager will report results of the audits to the administrator once a week. Food safety concerns will be verbally reported to the administrator immediately. The Registered Dietician will do a monthly in-services for the next six months to address issues identified during the audits. The Registered Dietician will perform one random audit per month for six months to assure ongoing compliance with preparing and offering therapeutic diets.	

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F 805	Continued From page 38 any residents. HM-F further indicated she did not understand how to implement the therapeutic diets. On 5/27/21, at 1:22 p.m. the registered dietician (RD) stated she was not aware residents were not offered the therapeutic diets, she discussed she expected the facility to follow the provider orders. On 5/27/21, at 2:00 p.m. the administrator indicated recent homemaker staff turnover and the current dietary manager was new to the role. The administrator further stated he was not aware residents were not receiving the physician ordered diets. On 5/27/21, at 3:00 p.m. the interim director of nursing (DON) was interviewed and stated she was not aware the facility was not providing the prescribed therapeutic diets and expected the therapeutic diets to be prepared for the residents. The DON indicated the expectation would be for all kitchen staff to be properly trained in preparing and serving therapeutic diets. On 5/27/21, at 4:00 p.m. the consultant registered dietician (RD)-A was interviewed on the telephone. RD stated her role in the facility was to complete all comprehensive nutrition assessments, MDS, care plans and CAA (initial, annual, and significant change assessments). On 5/27/21, at 4:28 p.m. on HM-G indicated she worked at the facility for three years. HM-G stated she offered the residents on floor 3B the regular meal tonight and did not offer any of the residents an alternative meal option. HM-G indicated she was not aware of the alternative menu options for	F 805	Dietary audit results will be reviewed at the quarterly QAPI meetings. 5. Date of completion July 1, 2021 and ongoing.	

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the residents until today, and further discussed the alternative therapeutic menu food options were not available in the kitchen tonight and did not know if alternative food options were available in the main kitchen.

On 5/27/21, at 5:45 p.m. HM-A stated she was not aware of residents being on physician ordered diets.

On 5/27/21, at 5:48 p.m. HM-F stated she had not been aware of individualized diet orders for residents prior to yesterday (5/26/21). HM-F obtained a document titled "Orders by Order Code" which indicated resident names and their physician-ordered diet, and stated "I don't understand what they [diet types] mean. When asked what soft mechanical diet meant, stated the food must be soft enough for a resident to chew it.

On 5/28/21, at 9:35 a.m. via telephone interview the RD discussed residents on a therapeutic diet, should be served what is listed on the column of the menu spread sheet. The RD provided the following document regarding services she provided to the facility including: Complete high-risk charting on all high-risk patients monthly. Referral sheet provided to RD by a dietary manager promptly upon entering building, Consult with patient/families as needed/upon request, Provide diet education as needed/upon request, Complete a written report of each monthly visit for Dietary Manager, Responsible for meeting all State and/or federal regulations, Conduct food service audit upon request

The facility policy titled Dietary Policies dated October 2017, indicated:

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F 805	Continued From page 40 Resident Diets The facility must provide each resident with a nourishing, palatable, well balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the preferences of each resident. Menus and Nutritional adequacy A. Menus meet the nutritional needs of residents in accordance with established national guidelines. B. The menus are prepared in advance. C. Menus are followed to the best extent possible, taking into consideration food inventory and resident choice. F. Menus are viewed by the facilities dietitian or other clinically qualified nutrition professional for the nutritional adequacy. Therapeutic diets: Therapeutic diets must be prescribed by the attending physician. The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by state law. Nutritional status The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. The policy titled St. John's Lutheran Community Position Description Homemaker date 5/2017, indicated: Regulatory compliance	F 805		

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F 805	Continued From page 41 1. Review, understand and follow residents written plan of care. Education: - Must be capable of reading and following residents care plans. Policy titled St. John's Lutheran Community Dietary compliance dated 1/21, included: Policy: Residents have the right to make their own choices about the diet. All diets need to be prescribed by a physician or mid-level practitioner or only persons authorized to write orders. Procedure: If a resident chooses not to follow his or her physician ordered diet, staff will perform the following procedure: 1.) Dietary staff or CNA will notify the nurse for that resident that they are expressing their desire not to follow their diet order. 2.) Nursing will educate the resident on why they have the prescribed diet, including risks and benefits. 3.) nursing will document in IPNs about the education provided, including risks and benefits, and what the resident chose to eat 4.) If the resident consistently declines to follow his/ her prescribed diet, the NP or PCP will be notified. 6.) If no changes are made to the prescribed diet and the resident continues to choose not to follow the order, a risk benefit statement may be filled out. However, education will still need to be done periodically and at scheduled care conferences by the nursing	F 805		
F 812 SS=K	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		6/1/21

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F 812	Continued From page 42 §483.60(i) Food safety requirements. The facility must - §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 properly prepare food to the appropriate temperature to ensure food safety and prevent foodborne illness. This deficient practice resulted in an immediate jeopardy (IJ) for 5 of 7 residents (R29, R60, R47, R23, R48) who ate undercooked food prepared and served from one of five facility satellite kitchens (kitchen 2B). Furthermore, the facility failed to ensure staff completed proper cleaning and sanitization of items and equipment, date when food items were opened, and monitor food storage temperatures to prevent foodborne illness. This deficient practice had the potential to affect all 58 residents receiving food from the kitchenettes.	F 812	F812 1. Residents who consumed pork (R29, R60, R47, R23, and R48) were monitored for foodborne illnesses. 2. All residents could potentially be impacted by this deficient practice. 3. All dietary staff and homemakers were trained on proper food serving temperatures prior to starting their shift on May 28, 2021, and was continue until all dietary staff and homemakers had been retrained on proper food temperatures. Training included the Food Safety Temperature module from Educare. Management staff observed dietary staff and homemakers taking temperatures prior to serving food in the household	

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F 812	Continued From page 43 The IJ began on 5/27/21, at 5:15 p.m. when the facility failed to serve food to residents at an appropriate temperature to prevent foodborne illness. The administrator and dietary director (DD)-A were notified of the immediate jeopardy at 5/28/21, at 1:44 p.m. The immediate jeopardy was removed on 5/30/21, but noncompliance remained at a lower scope and severity level of E - pattern, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an observation on 5/27/21, at 5:15 p.m. R58 was dining in her room and reported to surveyor her pork patty was cold to the touch. The burger was taken back to the unit kitchen by surveyor and temperature was taken by DD-A at 92 degrees Fahrenheit (F). The pork patty was observed to be pale gray/tan in color and had no char marks. On 5/27/21, at 5:20 p.m., a pork patty that homemaker (HM)-A had removed from the frying pan, placed on a bun, put on a plate, and covered with foil, was temped by DD-A at 89 degrees F. Furthermore, at 5:25 p.m., a pork burger that was prepared, plated, and set on a tray for room service for R55 was temped by DD-A at 87.6 degrees F. It was not known how long the pork burger had been sitting on the tray. DD-A stated the pork patties should have been cooked to 160 degrees F. R48 who had returned to his room after eating supper in the 2B dining room, left half of his uneaten pork burger on his plate. The middle of the pork patty was pale pink. DD-A was asked if the pork patty appeared fully cooked and	F 812	kitchens. A competency checklist was used to confirm staff competency. All dietary staff and homemakers were trained on temperature documentation procedures prior to their shift. Temperature documentation will be turned in at the end of the shift and reviewed by the Dietary Manager. Training began on May 28, 2021 and continued until all dietary staff and homemakers had been retrained on proper food temperatures. Education material was re-posted in each household kitchen with instruction for use of the food thermometer and required end-cooking temperatures. Staff were re-educated on July 1, 2021 to reinforce and assure proper dietary practices including food temps, food safety, and therapeutic diets. St. John□s consulting Registered Dietician is scheduled to do an in-service on July 21, 2021 to reinforce again the need to follow proper dietary practices. 4. Ongoing compliance will be monitor by The Dietary Manager 5 days a week for one month, and weekly for six months. Findings will be reviewed by the Administrator and the QAPI Committee. 5. Completion date: May 29, 2021 and ongoing.	

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replied, "it doesn't look appetizing."

On 5/27/21, at 5:35 p.m., HM-A admitted in the presence of DD-A, that she had not temped any of the pork patties she made for the 7 of 13 residents (R29, R60, R47, R58, R23, R48, R55) on unit 2B who requested a pork burger for their evening meal. Five of the seven residents consumed part of a pork burger before it was identified as being undercooked:

Of the seven residents who requested and received pork burgers for dinner on 5/27/21, five residents ate part of it:
1) R29: quarterly Minimum Data Set (MDS) dated 4/7/21, indicated a brief interview for mental status (BIMS) of 14, indicating intact cognition. MDS also indicated R29 could eat independently. R29 who dined in the 2B dining room, stated she took a couple of bites of the pork burger, but didn't like it so didn't eat more.
2) R60: quarterly MDS dated 5/12/21, indicated BIMS of 99, indicating R60 was not able to complete the BIMS interview. MDS also indicated she could eat independently. R60 who dined in her room consumed a portion of the pork burger.
3) R47: quarterly MDS dated 4/28/21, indicated BIMS of 14, indicating intact cognition. MDS also indicated she could eat independently. R47 was in her room with family members present. Noted a half eaten pork burger on her plate. When asked how the burger was, R47 stated she didn't care for it so didn't finish it.
4) R23: quarterly MDS dated 3/31/21, indicated BIMS of 09, indicating moderate impaired cognition. MDS also indicated she could eat independently. R23 who dine in her room consumed a portion of the pork burger.
5) R48: quarterly MDS dated 4/28/21, indicated

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BIMS of 11, indicating moderate impaired cognition. MDS also indicated he could eat independently. R48 who dined in the 2B dining room was observed to have eaten half of the pork burger.

Review of the pork patty vendor cooking instructions indicated the pork patties were raw and frozen when delivered and required cooking to an internal temperature of 155 degrees F and to hold at a temperature of 135 degrees or above.

During unit 2B satellite kitchen observation and interview on 5/24/21, at 4:35 p.m., HM-A stated she had been employed as a homemaker at the facility for about two weeks, adding she had five days of training with three different homemakers before starting on her own. In her position, she was responsible for preparing and serving meals to 13 residents currently residing on second floor, unit 2B.

During an interview on 5/26/21, at 8:13 a.m., DD-A stated the main kitchen in the basement supplied five satellite kitchens on three floors with uncooked food for lunch and dinner. Homemakers were responsible for cooking the food and serving it to residents on their unit.

During an interview on 5/26/21, at 10:12 a.m., DD-A stated there was no orientation training checklist for HM-A who started working at the facility on 5/13/21. DD-A stated, "to be honest, I don't think they are using the orientation checklists." According to DD-A, of the 23 homemakers employed, only two had a training checklist on file. The training checklist included hands-on skills such as how to take and record food temperatures. In addition, 12 out of 23

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homemakers had not completed their online training modules related to culinary topics such as food safety temperatures. According to DD-A, HM-A was first scheduled for online culinary training modules on 5/27/21, after concerns were identified with her temping food. DD-A verified her responsibility as dietary director to ensure homemakers were trained properly before working on their own, which included temping food and serving it at proper temperatures.

During interview on 5/27/21, at 1:30 p.m. with infection preventionist, reviewed the facility electronic infection surveillance log. No trends were identified and no symptoms related to foodborne illness were noted.

During an interview on 5/28/21, at 11:14 a.m., the administrator stated he was aware undercooked pork patties were served to residents on 5/27/21, and provided a document from the facility associated trade organization, titled Food Safety Requirements Policy and Procedure, dated 2017, which he stated the facility would be adopting for food safety guidance.

During separate interviews on 5/28/21, starting at 12:05 p.m., five residents (R29, R60, R47, R23, R48) who ate part or all of an undercooked pork burger on 5/27/21, were interviewed for signs and symptoms of foodborne illness. One resident, R47, stated "I filled my pants this morning" but denied other symptoms. During an interview at 12:20 p.m., nursing assistant (NA)-A stated R47 had a bowel movement (BM) "blow out" with stool running down her legs, but did not have a fever or other gastrointestinal symptoms.

During an interview on 5/28/21, at 12:25 p.m.

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registered nurse (RN)-A confirmed she was aware of residents being served undercooked pork patties the evening of 5/27/21. RN-A was not aware of any residents with signs or symptoms of foodborne illness and was not aware R47 had experienced loose stools. Review of R47's medication administration record indicated medication to treat constipation that had been given daily since 5/22/21, was held on 5/28/21, due to loose stools. RN-A stated that was unusual for R47. Review of R47's BM log indicated she had an "XXL" (extra, extra-large) BM on the 7 a.m. to 3 p.m. shift on 5/28/21. RN-A stated nurses and nursing assistants were monitoring these residents for signs and symptoms of foodborne illness.

During an interview on 5/28/21 at 1:45 p.m., the administrator stated he was unaware of homemakers on satellite kitchens not temping food and/or not temping food properly. The administrator admitted this could result in residents acquiring a foodborne illness. Administrator was not aware that some homemakers did not complete orientation checklists or culinary training modules before starting shifts on their own. Further, the administrator stated he would be working with DD-A to improve this process to ensure dietary staff have training to properly temp foods for resident consumption.

The immediate jeopardy that began on 5/28/21, was removed on 5/30/21, at 11:30 a.m. when the facility developed and implemented interventions to ensure food was prepared to appropriate temperature. All dietary staff and homemakers who prepared and served food to residents were trained on performing temperature checks and on

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 48	F 812		

proper food serving temperatures. In addition, management staff verified competency of food temperature compliance by observing dietary staff and homemakers temp food prior to serving it to residents. Visual references with instruction how to use a food thermometer and appropriate end cooking temperatures were posted in each household kitchen. It was verified through interviews that prior to their first shift of work following the identification of the IJ, dietary staff and homemakers completed online training modules related to temping food. In addition, dietary staff and homemakers completed a competency with a facility director on calibration of food thermometers, properly temping food, and documenting food temperatures. Observations and interviews of homemakers was conducted on each of the five-household kitchens to ensure competency. However, non-compliance remained at the lower scope and severity level of E - pattern, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Surveyor: Jordan, Alisha

On 5/24/21, at 1:50 p.m. the initial observation and tour of the main kitchen with the dietary manager (DM) revealed:
- A cupboard with a bag of white sugar and brown sugar not dated or sealed, and white sugar particles visible on the lower shelf of the cupboard.
- A metal sauce pan located in a lower cabinet had hard, brown substance around the inside of the cooking put.
-A box of lasagna noodles opened was found located on a metal shelf not dated and a clear

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	245635	A. BUILDING _____ B. WING _____	C 06/01/2021

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bag which reassembled pasta shells dated 12/20 and not labeled.
-The clean area where the clean dishes were located, had metal baking dishes on the counter and were stacked and placed on the counter to dry.
-A metal shelf located in the walk in freezer had and a bag of stator tots opened and not dated and clear plastic bag was filled with white string like food material located on a metal shelf, not dated and labeled lunch
-Ice fragments were located on the floor of the walk in freezer and multiple ice chunks were stacked on the floor and under the shelves near the door. The boxes to the left of the door on the metal shelf were covered with frost on the outside of the boxes, visible frost was located on the metal shelves and frost was built up on both of the doors frames of the walk in freezer.

On 5/24/21, at 2:15 p.m. an interview with the DM confirmed the pot was not clean. DM indicated the bags of sugar were expected to be sealed, dated, and the spilled sugar wiped and removed. The DM indicated dishes removed from the dish machine were not to be stacked until fully air dried. The DM indicated a nursing assistant was helping with the dishwashing due to no staff available, and stated she was not trained in dishwashing. DM discussed the freezer has always had frost and ice built-up and maintenance was aware. When asked when and what repairs were done for freezer the DM was not sure. The DM stated she was aware the refrigerator temperatures were not always checked daily.

On 5/24/21, at 3:00 p.m. the initial tour of the first floor kitchenette revealed:

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F 812	Continued From page 50 - Refrigerator temperature was at 50 degrees Fahrenheit (F) - Plastic container of strawberries located in the refrigerator was not dated - Small refrigerator with cardboard container with liquid egg whites opened and not dated - Plastic covered container with unknown contents not labeled or dated was found in the refrigerator - Refrigerator and freezer temperatures had blank areas for the dates of 5/15-5/21 On 5/24/21, at 3:15 p.m. the initial tour of the second floor kitchenette A revealed: - Oven inside had burnt, black layers of debris and food particles - Microwave on the inside was found to have food particles and inside walls of the microwave were found to have hard and dried food particles built up - Cupboard drawers were observed and found with food particles and crumbs - Clear plastic bag was on the counter and contained shredded wheat cereal and was not sealed, labeled or dated On 5/24/21, at 3:25 p.m. an interview with the DM indicated the cleanliness of the kitchen on 2A was not acceptable and indicated she expected the kitchen cleaned daily and stated "it" [kitchen] looks like a week or two without being cleaned. On 5/24/21, at 3:30 p.m. the initial tour of the second floor kitchenette B revealed: -Hairbrush was located on the counter by the microwave -Cupboards throughout the kitchen included : chicken flavor mix, beef gravy mix, powdered sugar and were opened and not dated	F 812		

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F 812	Continued From page 51 -Small fridge contained liquid eggs in a cardboard container opened not dated -Top handle of the small refrigerator felt greasy and sticky and visibly had greasy substance -Food crumbs and food particles observed in all cupboard drawers -Bread in a kitchen drawer was found opened not dated -Food particles were dried onto the floor and food crumbs/particles were built up in the corners of the floor. The 2B refrigerator was found top shelf with 3 plates stacked on top of each other covered with aluminum foil not labeled or dated - All food on refrigerator top shelf was not dated - Drawer in the refrigerator had a clear plastic bag of brown wilted lettuce, not opened and not dated and further observed the DM to discard -Milk, juice, cake, and hard boiled (located in a plastic bag) were opened not dated -A staff member was observed to take plastic cups out of the dishwasher, steam were on the cups and wetness was observed on the plastic cups, the staff member used a red rag and wiped inside and outside of the glasses dry On 5/24/21, at 3:45 p.m. an interview with the DM stated the drinking glasses should not be wiped with a rag and the staff member was a nursing assistant who was not trained in the kitchen and the DM further indicated the refrigerators were expected to have dates of the food opened needed to be cleaned. On 5/25/21, at 9:37 a.m. observed homemaker (HM)-G exited the 3B kitchen and failed to wash her hands when she reentered the kitchen. Further, HM-G removed oatmeal from the	F 812		

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F 812	Continued From page 52	F 812		

microwave, removed two drinking glasses from the cupboard, poured a glass of juice and glass of milk, and exited the kitchen. HM-G provided the glass of juice and milk to the resident in the dining area, and failed to wash or sanitize her hands. HM-G was further observed to reenter the kitchen and removed bacon from a pan on the stove top. HM-G provided the bacon to a resident and failed to check the temperature of bacon.

On 5/27/2, at 9:44 a.m. observed HM-G in kitchen and placed her un-gloved bare hand in a bag of shredded cheese and placed the shredded cheese on eggs. The eggs with cheese was served to the resident. When asked, HM-G confirmed gloves should be worn when handling food and indicated she failed to do so.

On 5/25/21, at 9:00 a.m. the DM manager provided a written list of the items she discarded from the second floor refrigerators and cupboards on 5/25/21 between 7:00 a.m. and 7:30 a.m. . The written listed indicated the following were opened and not dated, and therefore the DM indicated she discarded the following foods: hard boiled eggs, milk, juice, deli meats, cream cheese, grated cheese, lettuce, leftovers (not identified), bacon, bread, peanut butter, brown sugar, syrup, pancake mix, oatmeal.

On 5/25/21, at 10:23 a.m. observed unidentified homemaker in the kitchen with no gloves, used cooking utensil to stir food, then touched a walkie talkie, drank water out of water bottle, and further observed to continue to prepare food and stir food on the stove top and failed to wash hands.

On 5/25/21, at 1:55 p.m. HM-D was located in

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F 812	Continued From page 53	F 812		

kitchen 2A, and stated she did not record the freezer temperatures today, because she could not find the thermometer and further indicated the freezer temp need to be at 32 degrees or less. HM-D failed to state and understand the correct freezer temperature food was stored.

On 5/25/21, at 2:00 p.m. observed second floor B kitchen the self cleaning oven was in use. HM-E discussed the oven should be cleaned once a week, and further stated she was not aware when it was cleaned last. HM-E stated the fridge temps need to be at 37-47 degrees and freezer less then 0. When asked, to see the prepared food temperatures, HM-E stated she had not wrote down the food she temped today, because she does it at the end of her shift and remembers the food and the temperatures.

On 5/25/21, 03:07 p.m. interview with the DM stated she could not find documentation of maintenance repairs since 2018, for the main kitchen walk-in freezer.

On 5/26/21, at 9:00 a.m. HM-H was observed working on the 3B kitchen and stated the pancakes for breakfast were temped at 172 degrees F. HM-H further indicated she failed to temp the bacon and sausage served to the residents for breakfast. HM-H confirmed food should be temped when served to the residents.

On 5/27/21, at 1:30 p.m. interview with the DM indicated she was new to the manager role and also has many new dietary staff who needed to be trained about labeling and dating food items before putting them back in dry food storage, the refrigerator and the freezer, and further indicated was ultimately responsible to assure all foods

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F 812	Continued From page 54 were labeled and dated. Interview with the administrator on 5/28/21 at 1:45 p.m. stated-he was unaware the kitchen had items in dry food storage, refrigerator and freezer were not labeled and dated and the residents food was not temped prior to being served. Facility policy titled Dietary Policies, dated October 2017, indicated: 1. Each resident received, and the facility provided: --Food prepared by methods that conserved nutritive value, flavor, and appearance. Food and drink were palatable, attractive, and served at a safe and appetizing temperature. --Food would have taste, aroma, and appearance that encouraged resident consumption of food. 2. Potentially hazardous food would be maintained at 40 degrees Fahrenheit (F) or below, or 150 degrees (F) or above including periods when it was being transported. 3. "Potentially hazardous food" meant any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. Facility memo titled Policy on Food Temperatures, dated 11/1/08, indicated: Food temperatures would be taken before food was served to residents. Minimum temperature was 150 degrees. If temp was below 150, food was to be microwaved or sent back to the kitchen for replacement. Facility policy titled Employee Education and dated 3/1/21, indicated:	F 812		

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F 812	Continued From page 55 --All employees were assigned online orientation education at hire and were to complete the education prior to job/floor training beginning. The policy titled St. John's Lutheran Community Position Description Homemaker date 5/2017, indicated: Regulatory compliance 1. Review, understand and follow residents written plan of care. Education: - Must be trained in "serve safe" practices. - Must be capable of reading and following residents care plans. The policy titled St. John's Lutheran Community Position Description Certified Dietary Manger/Culinary Manager dated 9/2017, indicated: Operations Management: -Interview, hire, train, coach, evaluate, discipline, employees and when necessary work with HR to fire employees. -Develop job duties. Facility policy titled Employee Education and dated 3/1/21, indicated: --All employees were assigned online orientation education at hire and were to complete the education prior to job/floor training beginning. Document titled Use of plastic gloves (not rated) indicated: Policy: Plastic gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handlers hands to the food product being served. Procedure:	F 812		

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F 812	Continued From page 56 1. If used, single use gloves shall be used for only one task such as working with ready to eat food or raw animal food, used for no other purpose, and discarded when damaged or soiled , or with interruptions occur in the operation. 2. Hands are to be washed when entering the kitchen before putting on the plastic gloves. 3. Plastic gloves are to be worn whenever handling the food directly with hands when handling ready to eat foods, anytime you touch food directly. 4. Remember gloves are just like hands they get soiled anytime a contaminated surface is touched the glove must be changed. During food preparations as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, after using the restroom. Document titled Reminders dated 4/14/14 indicated, Make sure you're taking temps of the food you are making and recording it on the sheet and initial them when you're done. When you're done cleaning make sure you're signing the cleaning sheet if you don't sign it, it's not done. Before you put away your dish make sure they are dry bacteria grows in dark wet places Document titled policy and food temperatures dated 11/1/2008, indicated: Food temperatures will be taken before food is served to residents. Minimum temperature is 165 degrees. If temp is below 165, food is to be microwaved or sent back to the kitchen for replacement. Document titled dietary policies dated October 2017, indicated:	F 812		

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F 812	Continued From page 57 Air drying dishes and utensils must be air dried before being stored or must be stored in a self-driving position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available Document titled storing leftovers dated 9/22/12, indicated. All leftovers are to be dated and labeled. They are to be covered. Can be help for three days then discarded. Dry storage items such as Jell-O and noodles are to be placed in a sealed container labeled and dated. No food item is to be left in original bag and sealed with the twisty no food items should be stored on the floor everything needs to be in a shelf or rack. All food past expiration date is to be thrown. Policy titled refrigeration policy dated 8/22/2012, indicated. All refrigerators are to be kept clean and in good working condition at all times. Temperatures for a refrigerator should be between 36 through 40 degrees if above please let supervisor know shut off light and keep door closed as much as possible. Every refrigerator should be equipped with an internal thermometer. each nursing unit with the refrigerator/freezer unit will be supplied with thermometers and monitored for appropriate temperatures. Cooked foods must be stored above raw food to prevent contamination. All food should be covered and labeled and dated. All foods should be allowed to allow air circulation. Document titled freezer and walk in policy dated	F 812		

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F 812	Continued From page 58 11/1/2008, indicated Temperatures will be checked twice daily. Cook will check the walk in another refrigerator at the start of the shift cook will check between 3:00 and 4:00 o'clock, the temp should be between 33 and 40 degrees. Freezers will be checked by the CA when getting supplies temperatures should be at zero degrees or below if temperatures are not correct report to maintenance.	F 812		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/25/2021. At the time of this survey, St. John's on Fountain Lake Building 01 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. John's on Fountain Lake - Bldg 01 is a 1 story building with a basement. The facility was constructed in 2014 and was determined to be of Type II (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, and spaces open to the corridors and lower level that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 84 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system installation in accordance with NFPA 101 2012 edition, Life Safety Code, section 9.7.1.1, and NFPA 13 2010 edition, Standard for the Installation of Sprinkler Systems, section 6.2.5.1. This deficient practice could affect all residents within the room.	K 351	K351 Description of what has been, or will be, done to correct the deficiency. Olympic Fire and Sprinkler will replace dry sprinkler heads in walk in freezer as soon as the parts arrive. They advised if liquid is still in the head we are still in compliant. Based on personal investigation as well as advisement from Olympic Fire there is	8/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **01 - ST JOHNS ON FOUNTAIN LAKE** B. WING _____	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

(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
K 351	Continued From page 3 Findings include: On a facility tour between the hours of 9:00 AM and 1:00 PM on 5/25/2021, it was revealed that the liquid in the fire sprinkler frangible bulbs no longer retained their colored liquid indicating their temperature rating. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 351	still liquid in the frangible bulbs. The liquid loses color due to the cold temperatures in freezer and the florescent lighting. The actual, or proposed, completion date. 8/2/2021 The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Aric Bauman, Maintenance Director	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the corridor wall	K 362	K362 Description of what has been, or will be,	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **01 - ST JOHNS ON FOUNTAIN LAKE** B. WING _____	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE** **ALBERT LEA, MN 56007**

(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
K 362	Continued From page 4 separating the two adjoining buildings in accordance with NFPA 101 2012 edition, Life Safety Code, section 19.1.3.5 and 8.2.1.3. This deficient practice could affect all 84 residents. Findings include: On a facility tour between the hours of 9:00 AM and 1:00 PM on 5/25/2021, it was revealed that the facility failed to seal a penetration around a 1-1/2 inch pipe passing through the fire-rated wall adjoining buildings B and D. This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 362	done to correct the deficiency. Upon discovery of breach in fire wall facility immediately filled the 1-1/2 inch pipe with a fire rated putty. We will continue to monitor and inspect all vendors who run cable, conduit, and or wiring to ensure fire wall barriers are not breached. The actual, or proposed, completion date. 5/26/2021 Work Order# 4568 The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Aric Bauman, Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **02 - 1771 EAGLEVIEW CIRCLE** B. WING _____	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE** **ALBERT LEA, MN 56007**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 25, 2021. At the time of this survey, St. John's on Fountain Building 2 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.	K 000		

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

Electronically Signed | 07/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **02 - 1771 EAGLEVIEW CIRCLE** B. WING _____	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE** **ALBERT LEA, MN 56007**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. John's on Fountain Lake - Building 02 is a 3 story building and was constructed in 2014 and was determined to be of Type II (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, and spaces open to the corridors and lower level that are monitored for automatic fire department notification.	K 000		

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	245635	A. BUILDING **02 - 1771 EAGLEVIEW CIRCLE** B. WING _____	**05/26/2021**

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ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE** **ALBERT LEA, MN 56007**

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K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system installation in accordance with NFPA 101 2012 edition, Life Safety Code, section 9.7.1.1, and NFPA 13 2010 edition, Standard for the Installation of Sprinkler Systems, section 6.2.5.1. This deficient practice could affect all residents within the room.	K 351	K351 Description of what has been, or will be, done to correct the deficiency. Olympic Fire and Sprinkler will replace dry sprinkler heads in walk in freezer as soon as the parts arrive. They advised if liquid is still in the head we are still in compliant. Based on personal investigation as well as advisement from Olympic Fire there is	8/2/21

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	245635	A. BUILDING **02 - 1771 EAGLEVIEW CIRCLE** B. WING _____	**05/26/2021**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 362	Continued From page 4 of Walls in accordance with (NFPA 101 2012 & NFPA 99 2012), (Life Safety Code / Health Care Facilities Code), Section 19.3.6.2, 19.3.6.2.7. This deficient practice could affect all 58 of residents. Findings include: On a facility tour between the hours of 9:00-1:00 pm on 5/25/2021, it was revealed that the facility failed to maintain a 1 1/2" pipe located in the fire wall between building B & D was not sealed from allowing smoke and heat to pass through in accordance with (NFPA 101 2012 & NFPA 99 2012). This deficient practice was verified by the Facility Maintenance Director at the time of discovery.	K 362	done to correct the deficiency. Upon discovery of breach in fire wall facility immediately filled the 1-1/2 inch pipe with a fire rated putty. We will continue to monitor and inspect all vendors who run cable, conduit, and or wiring to ensure fire wall barriers are not breached. The actual, or proposed, completion date. 5/26/2021 Work Order# 4568 The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Aric Bauman, Maintenance Director	