Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 27, 2023

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: CCN: 245407
Cycle Start Date: March 8, 2023

Dear Administrator:

On March 8, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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, Minnesota 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 8, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 8, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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
	245407	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/6/23, to 3/8/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		3/10/23

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

Electronically Signed | 04/05/2023

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.1.1.4, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 3/8/23 between 10 a.m. and 3 p.m., it was revealed during documentation review that there was no documentation presented to confirm that the once every 36 months - 4 hour continuous run of the emergency generator is occurring. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	E 041	The 4 hour load bank test was completed 3/10/2023 by Interstate Power Systems, 21568 Highview Ave. Lakeville, MN 55044. 9522-854-5511. Implemented program/schedule with Interstate Power systems to test 4 hour load bank on generator every 36 months. Added 4 hour load bank testing to yearly generator checklist. Plant Ops director or designee will monitor overall compliance.	
F 000	INITIAL COMMENTS On 3/6/23, to 3/8/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued: H54079000C (MN85958) and H54079001C (MN86901). 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	F 000		

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F 000	Continued From page 4 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, observation and document review, the facility failed to document and monitor weight status for 1 of 1 resident (R28) who has a history of edema and fluid retention. Findings include: R28's face sheet printed on 3/8/23, included diagnoses of chronic obstructive pulmonary disease (progressive lung disease with airflow limitations and variable respiratory symptoms), aortic valve stenosis (narrowing of heart valve that separates the pumping chamber of the heart to the rest of the body), and hypertensive heart failure (high blood pressure causing thickening of	F 684	R28 weights reviewed and were stable with no change in diuretic since 6/2021. Reviewed with medical provider and weight monitoring twice a week discontinued. Audits of other residents with ordered weight monitoring completed. Reviewed stable weights with provider and discontinued per provider orders. Weight monitoring policy reviewed and updated. Nursing staff training on weight monitoring to be completed by 5/3/23. Audits of weights will be completed weekly x 3 months, then monthly x 3 months. QAPI Committee will monitor and make further recommendations.	5/3/23

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F 684	Continued From page 5 the heart muscle). R28's quarterly Minimum Data Set (MDS) assessment dated 2/5/23, indicated R28 had moderate cognitive impairment, no weight loss or gain, uses oxygen therapy and takes a diuretic daily. R28 required extensive assist of 1 to 2 persons for activities of daily living. R28's care plan dated 8/11/22, indicated R28 had a potential for alteration in tissue perfusion related to heart failure, aortic stenosis, diabetes, and respiratory failure. Interventions included observe for changes in edema, weigh 2 times weekly and give medications including Lasix (diuretic) per physician orders. R28's physician orders dated 1/17/22, indicated R28's weight was to be obtained twice a week on Tuesday and Friday and to contact primary care provider for 2 pound increase in 2 days or 5 pound increase in a week. During observation on 3/7/23, at 12:39 p.m. R28 was sitting in recliner with legs elevated with elastic stockings on. R28 had minimal to no edema present on lower extremities. R28 had loose sounding cough. Review of R28's weights from 9/1/22 through 3/3/23 included opportunities for 70 weights with 19 not completed. Gaps in weights included: 9/19/22 to 9/26/22, one missed 9/26/22 to 10/3/22, one missed 10/3/22 to 10/19/22, four missed 10/25/22 to 11/4/22, two missed 11/11/22 to 11/18/22, one missed 11/22/22 to 12/2/22, two missed 12/16/22 to 12/23/22, one missed	F 684	QA&A will review at next meeting on 4/28/23. Director of Nursing/designee will monitor overall compliance.	

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F 684	Continued From page 6 12/23/22 to 12/30/22, one missed 12/30/22 to 1/6/23, one missed 1/20/23 to 1/27/23, one missed 2/10/23 to 2/17/23, one missed 2/17/23 to 3/3/23, three missed During interview on 3/8/23, at 1:36 p.m. nursing assistant (NA)-B indicated R28 is weighed on Tuesdays and Fridays. NA's report the weight to the nurse who documents it. NA-B provided an aide sheet that included weights to be completed on Tuesday and Friday. During interview on 3/8/23, at 1:50 p.m., registered nurse (RN)-A reviewed plan of care and indicated R28 is to be weighed Tuesday and Fridays. During interview on 3/08/23, at 1:53 p.m., the director of nursing (DON) evaluated weights and confirmed there were multiple missing weights. During interview on 3/8/23 at 2:15 p.m., the DON was able to locate 2 weights after 2/17/23 and added the unit was having difficulty with the scale around 2/24/23. Facility policy and procedure dated 10/28/22, for weight monitoring included: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates this is not possible or resident preferences indicate otherwise -weights should be recorded at the time obtained..if clinically indicated, monitor weight	F 684		

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F 684	Continued From page 7 daily or as directed by medical provider.	F 684		
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. §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 ensure 1 of 2 residents (R24) received assistance with hand splints to prevent worsening of range of motion. Findings include: R24's Diagnosis Report printed 3/8/23, included diagnosis of hemiplegia and hemiparesis (total or nearly complete paralysis on one side of the body), speech and language deficits, and Alzheimer's disease. R24's quarterly Minimum Data Set (MDS)	F 688	Therapy orders requested and received to address R24 right hand splint. R24 does not keep splint on and removes per self. R24 currently has a ROM program in place for her hands. Audits will be completed of therapy notes on all residents to ensure recommendations have been implemented. Have implemented functional maintenance program procedures and processes to ensure therapy orders are implemented and added to functional maintenance program charting. These	5/3/23

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F 688	Continued From page 8 assessment dated 3/5/23, identified R24 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. The MDS further identified R24 required extensive to total assistance for activities of daily living (ADL's) and had no rejection of cares. Functional limitation in range of motion (ROM) of upper (shoulder, elbow, wrist, and hand) showed R24 had impairment on one side and and lower extremities (hip, knee, ankle, and foot) with impairment on both sides. R24's care plan dated 10/24/19, included R24 required total assist with ADL's and had an alteration in mobility. Interventions included passive range of motion to right upper extremity. R24 was last evaluated by occupational therapy on 5/3/22 for wheelchair positioning deficits related to sliding out of her chair. R24 was previously evaluated and treated 12/2/20 through 2/6/21 for joint mobility for range of motion deficits to right upper extremity (RUE). Goal included patient will trial various splints to determine most appropriate for day or night use to prevent further spasticity and contracture in RUE. Discharge plans and instructions included apply splint at appropriate times and if patient flings off no need to put it back on. During observation and interview on 3/6/23, at 4:23 p.m. R24 was lying in bed. Right arm was lying by her side and right thumb was tucked under her fingers which were curled in towards the palm of her hand. A family member (FM)-A indicated he doesn't believe R24 has ever had a splint for her right hand. During observation on 3/7/23, at 8:10 a.m. R24	F 688	are reviewed and audited monthly with therapy at Range of Motion Meeting. Reviewed ROM policy and Functional Maintenance Policy. Nursing staff training on functional maintenance program to be completed by 5/3/23 All therapy recommendations are being monitored by Health Records or designee for implementation and compliance. QAPI Committee will review results and will also review at QA&A meeting which is next scheduled 4/28/23.	

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F 688	Continued From page 9 was sitting in her Broda chair (positioning wheelchair) in dining room. No splint was present on her right hand and right fingers curled in towards palm. During observation and interview on 3/7/23, at 12:28 p.m. nursing assistant (NA)-A was assisting R24 with lunch. R24's right arm was on the armrest of the chair. R24 would move her arm which flopped down towards the side of the wheelchair. R24 did not move her right hand and no splint was present. NA-A indicated R24 frequently will move her right arm so it falls off the arm of the chair but has not seen her move her right hand or fingers at all. NA-A asked R24 to move her fingers with no movement noted. R24's thumb was tucked into her palm with fingers curled over the thumb but not touching the palm. NA-A indicated R24 does not have a splint for her right hand. During observation on 3/8/23, at 7:20 a.m., R24 was asleep in bed. No hand splint was present on right hand. During interview on 3/8/23, at 9:35 a.m., NA-B indicated it has been a few years since R24 last wore a splint. NA-B added they do range of motion (ROM) twice a day and are able to move her fingers, but R24 says "owie" the whole time. R24's right hand is paralyzed but she can move her right arm. During interview on 3/8/23, at 8:21 a.m., registered nurse (RN)-A indicated R24 does not have a hand splint. During observation on 3/8/23, at 1:27 p.m., R24 was asleep in bed with no hand splint on right hand.	F 688		

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	245407	A. BUILDING _____ B. WING _____	C 03/08/2023

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F 688	Continued From page 10 During interview on 3/8/23, at 8:28 a.m. occupational therapist (OT)-A indicated the last occupational therapy evaluation for R24 was for positioning in wheelchair and nothing was mentioned about her right hand. The last time R24 was seen for her right hand was February 2021 for hand splint use. OT-A indicated therapy should be notified if staff are going to stop using a hand splint so other options can be evaluated. Staff should not just discontinue use of a splint. During interview on 3/8/23, at 2:08 p.m., the director of nursing (DON) indicated she evaluated R24 and she was able to open her right hand without R24 saying ouch. After looking through R24's electronic medical record (EMR), the DON indicated the last notes she could locate were from January 2021 and R24 was to wear the splint at night but the resident would remove the right hand splint herself. The DON added she doesn't know what happened with the splint and would look for it in R24's room. A progress note dated 1/26/21, at 5:56 a.m. included staff reported that R24 had hand splint on approximately 2 hours, then removed it herself. A progress note dated 1/26/21, at 2:40 p.m. indicated R24 takes splint off a short time after putting it on. A progress note dated 1/31/21, at 5:07 a.m. included overnight staff reported R24 removed hand splint shortly after putting it on. Facility policy and procedure titled Functional Maintenance Policy, undated, included implement of a functional maintenance program may occur	F 688		

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F 688	Continued From page 11 following a course of physical, occupational or speech therapy. In these cases, the therapist will provide resident specific training to the appropriate staff members, assist nursing in establishing initial goals and suggest interventions and approaches. The interdisciplinary team will determine when to discontinue the functional maintenance program and develop the follow-up interventions to be provided by general nursing staff.	F 688		
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 for 1 of 2 residents (R28) who was identified as on a mechanically altered (cut up meats) diet. Findings include: R28's face sheet printed 3/8/23, included diagnosis of dysphagia (difficulty in swallowing food or liquid), pneumonia and diabetes mellitus. R28's signed physician orders dated 10/19/2022, indicated a diabetic diet, and cut meat into bite size pieces. R28's quarterly Minimum Data Set (MDS) assessment dated 2/5/23, indicated R28	F 805	Initiated correct diet order immediately for R28. R28 refused. Diet order reviewed with R28 and resident representative. Risk and benefit reviewed and diet waiver signed. Audits of diets and speech therapy orders/recommendations will be completed for all residents. Implementing diet order procedure for speech therapy department to ensure all diet orders are received by nursing and dietary department. Training will be completed by 5/3/23 for therapy and nursing staff. Dietician will receive copy of weekly therapy report to monitor for changes and ensure compliance. Audits will be completed weekly x 4 weeks then monthly	5/3/23

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F 805	Continued From page 12 understands and is understood, has moderate cognitive impairment, requires supervision with eating, able to feed self and has no swallowing difficulties. R28's plan of care dated 2/5/23, included an alternation in nutritional status related to diabetes and history of cerebral infarction with right sided weakness and dysphagia. R28 requires adaptive eating utensils and staff to cut meat. Interventions included eats meals at nurses station, R28 to feed himself after meal is setup by staff and meat is cut up and resident will follow guidelines set up by speech therapy on 2/11/22. Black handled weighted silverware to aid with self feeding. A speech therapy discharge note dated 2/11/22, indicated R28 was discharged to continue with current diet, and cut up solids. Patient should continue to utilize cue card to help with recall and use of taught safe swallow strategies. During interview and observation on 3/6/23, at 3:22 p.m. R28 was sitting in his recliner in his room. A sign on the wall next to the recliner stated "Safe Swallow Strategies" which included small single sips of liquid, eat slow, cut up solids into small bites, alternate between food and liquid and was dated 1/21/22 from speech therapy. R28 indicated no one ever cuts up his food and denied any issues with chewing or swallowing. During observation on 3/7/23, at 12:09 p.m. R28 was eating lunch in the dining room. R28 had beef tips with gravy and mashed potatoes. Beef tips were not cut into bite size pieces. R28 ate without any choking incidents. There was no cue card present.	F 805	x 2 months. Audit information will be reviewed at QAPI Meeting and QA&A which is scheduled for 4/28/23.	

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F 805	Continued From page 13 During observation on 3/8/23, at 7:50 a.m. R28 was in the dining room with a round sausage whole patty and boiled egg on his plate. Neither were cut into bite size pieces. There was no cue card present on the table. During observation on 3/8/23, at 11:20 a.m. dietary aide (DA)-A was preparing meals for delivery to the residents on floor 2. DA-A placed a hamburger on a bun and potato wedges on R28's plate. Review of meal sheet indicated R28 was on diabetic diet with 1/2 dessert portions. During observation on 3/8/23, at 12:10 p.m. R28 was on floor 2 in dining area with a hamburger on a bun and potato wedges present. Food was not cut into bite size pieces. R28 ate 1/3 of his hamburger and 1/2 of potato wedges. There was no cue card present at R28's table. During interview on 3/8/23 at 12:15 p.m. nursing assistant (NA)-C indicated normally the kitchen cuts up R28's food. When questioned why R28's hamburger wasn't cut into bite size pieces, NA-C indicated R28 can eat sandwiches without being cut up, but meats like turkey need to be cut up. During interview on 12/8/23, at 12:18 p.m. registered nurse (RN)-A indicated R28 has a tendency to chew his food too fast and had been seen by speech therapy who told him to slow down when eating. RN-A indicated staff will ask R28 if he wants his food cut up or not. During interview on 3/8/23, at 12:20 p.m. R28 stated everything is supposed to be cut up but they never do it. R28 denied choking on his food. R28 further stated no one asks him if he wants	F 805		

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F 805	Continued From page 14 his food cut up or not. During interview on 3/8/23 at 12:30 p.m. cook (C)-A indicated R28 is on a carbohydrate consistent, regular texture thin liquids diet with 1/2 portion of dessert. There was no mention of meat being cut up on the diet order the kitchen had but will discuss it with the registered dietician (RD). During interview on 3/8/23 at 1:27 p.m. RD indicated the kitchen did not receive notification to the change in diet order. Requested to see sign/recommendations speech therapy (ST) posted in R28's room, which she then reviewed. After reviewing sign and ST notes, the RD indicated somehow communication did not occur between ST, nursing and the kitchen. The RD added per current standards a Dysphagia easy to chew, level 7 diet would be appropriate which includes moistened tender meats, thin-sliced deli meats (cut up or chopped). During interview and observation on 3/8/23 at 1:35 p.m. NA-B approached the RD and indicated she found R28's swallowing strategies card on another table and will tape it to R28's table so it doesn't get moved again. During interview on 3/8/23 at 2:40 p.m. the director of nursing (DON) confirmed the diet order was missed. Facility policy and procedure titled Standard Diets dated 3/2018, included diet order terminology will be used to assure consistency and accuracy in providing the diets per physician order. Clarification will be requested by the dietician or charge nurse to the physician on diet orders	F 805		

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F 805	Continued From page 15 noted in the standard terminology.	F 805		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 27, 2023

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Re: State Nursing Home Licensing Orders
Event ID: 986D11

Dear Administrator:

The above facility was surveyed on March 6, 2023 through March 8, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/6/23, to 3/8/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey. H54079000C (MN85958) and H54079001C (MN86901). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a 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 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R24) received assistance with hand splints to prevent worsening of range of motion. Findings include: R24's Diagnosis Report printed 3/8/23, included diagnosis of hemiplegia and hemiparesis (total or	2 890	Corrected	5/3/23

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2 890	Continued From page 3 nearly complete paralysis on one side of the body), speech and language deficits, and Alzheimer's disease. R24's quarterly Minimum Data Set (MDS) assessment dated 3/5/23, identified R24 had a Brief Interview for Mental Status (BIMS) score of 0 indicating severe cognitive impairment. The MDS further identified R24 required extensive to total assistance for activities of daily living (ADL's) and had no rejection of cares. Functional limitation in range of motion (ROM) of upper (shoulder, elbow, wrist, and hand) showed R24 had impairment on one side and and lower extremities (hip, knee, ankle, and foot) with impairment on both sides. R24's care plan dated 10/24/19, included R24 required total assist with ADL's and had an alteration in mobility. Interventions included passive range of motion to right upper extremity. R24 was last evaluated by occupational therapy on 5/3/22 for wheelchair positioning deficits related to sliding out of her chair. R24 was previously evaluated and treated 12/2/20 through 2/6/21 for joint mobility for range of motion deficits to right upper extremity (RUE). Goal included patient will trial various splints to determine most appropriate for day or night use to prevent further spasticity and contracture in RUE. Discharge plans and instructions included apply splint at appropriate times and if patient flings off no need to put it back on. During observation and interview on 3/6/23, at 4:23 p.m. R24 was lying in bed. Right arm was lying by her side and right thumb was tucked under her fingers which were curled in towards the palm of her hand. A family member (FM)-A	2 890		

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2 890	Continued From page 4 indicated he doesn't believe R24 has ever had a splint for her right hand. During observation on 3/7/23, at 8:10 a.m. R24 was sitting in her Broda chair (positioning wheelchair) in dining room. No splint was present on her right hand and right fingers curled in towards palm. During observation and interview on 3/7/23, at 12:28 p.m. nursing assistant (NA)-A was assisting R24 with lunch. R24's right arm was on the armrest of the chair. R24 would move her arm which flopped down towards the side of the wheelchair. R24 did not move her right hand and no splint was present. NA-A indicated R24 frequently will move her right arm so it falls off the arm of the chair but has not seen her move her right hand or fingers at all. NA-A asked R24 to move her fingers with no movement noted. R24's thumb was tucked into her palm with fingers curled over the thumb but not touching the palm. NA-A indicated R24 does not have a splint for her right hand. During observation on 3/8/23, at 7:20 a.m., R24 was asleep in bed. No hand splint was present on right hand. During interview on 3/8/23, at 9:35 a.m., NA-B indicated it has been a few years since R24 last wore a splint. NA-B added they do range of motion (ROM) twice a day and are able to move her fingers, but R24 says "owie" the whole time. R24's right hand is paralyzed but she can move her right arm. During interview on 3/8/23, at 8:21 a.m., registered nurse (RN)-A indicated R24 does not have a hand splint. During observation on 3/8/23, at 1:27 p.m., R24	2 890		

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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) COMPLETE DATE
2 890	Continued From page 5 was asleep in bed with no hand splint on right hand. During interview on 3/8/23, at 8:28 a.m. occupational therapist (OT)-A indicated the last occupational therapy evaluation for R24 was for positioning in wheelchair and nothing was mentioned about her right hand. The last time R24 was seen for her right hand was February 2021 for hand splint use. OT-A indicated therapy should be notified if staff are going to stop using a hand splint so other options can be evaluated. Staff should not just discontinue use of a splint. During interview on 3/8/23, at 2:08 p.m., the director of nursing (DON) indicated she evaluated R24 and she was able to open her right hand without R24 saying ouch. After looking through R24's electronic medical record (EMR), the DON indicated the last notes she could locate were from January 2021 and R24 was to wear the splint at night but the resident would remove the right hand splint herself. The DON added she doesn't know what happened with the splint and would look for it in R24's room. A progress note dated 1/26/21, at 5:56 a.m. included staff reported that R24 had hand splint on approximately 2 hours, then removed it herself. A progress note dated 1/26/21, at 2:40 p.m. indicated R24 takes splint off a short time after putting it on. A progress note dated 1/31/21, at 5:07 a.m. included overnight staff reported R24 removed hand splint shortly after putting it on. Facility policy and procedure titled Functional	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	C 03/08/2023

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2 890	Continued From page 6 Maintenance Policy, undated, included implement of a functional maintenance program may occur following a course of physical, occupational or speech therapy. In these cases, the therapist will provide resident specific training to the appropriate staff members, assist nursing in establishing initial goals and suggest interventions and approaches. The interdisciplinary team will determine when to discontinue the functional maintenance program and develop the follow-up interventions to be provided by general nursing staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise policies and procedures related to the facility restorative program to include splint use. The DON, or designee, could provide training for all nursing staff related to the policies and procedures. The quality and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		

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	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2023**

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

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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 03/08/2023. At the time of this survey, ST JOHNS LUTHERAN HOME was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2023

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 JOHNS LUTHERAN HOME is a 2 story building with partial basement. The building was constructed at 5 different times. The original building was constructed in 1961 and was determined to be Type II (000) construction. In 1972 and addition was added and was determined to be Type II (000) construction. In 1987 and addition was added and was determined to be Type II (222) construction. In	K 000		

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K 000	Continued From page 2 1991 and addition was added and was determined to be Type II (000) construction, with a portion of the addition being of Type V (111) construction. In 2000 and addition was added and was determined to be Type III (211) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		4/4/23

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K 211	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1, and 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed by observation that all perimeter exit doors, except the front entrance to the facility, were coveraged with snow and ice. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	Sidewalks and door exits will be checked daily during the winter season to make sure all pathways are clear from snow and ice. If walkways and exits are compromised, they will be cleared as soon as possible with proper removal equipment, sand, salt or grit to help.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test operability of emergency lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.3.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 291	A document was created for the testing of emergency and exit lighting. (see attachment) Maintenance will provide monthly 30 second tests and a 90 minute annual test. The Safety Committee will monitor and audit these tests quarterly and the Maintenance Director will report to the QA&A committee that meets quarterly.	4/4/23

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K 291	Continued From page 4 On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during documentation review that there was no evidence presented to confirm that emergency lighting devices are being tested. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 291		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and	K 353	1. Maintenance Director has set up testing with our service provider to have system testing on a Quarterly basis. Testing is set up for January, April, August and November. Maintance will monitor these reports on a quarterly basis and	4/28/23

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K 353	Continued From page 5 Maintenance of Water-Based Fire Protection Systems, sections, 4.3.1, 4.3.2, 4.3.3, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.2, NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during a review of available documentation that no fire sprinkler system quarterly inspection reports were presented for review for 3rd and 4th quarters of 2022 2. On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during the tour of the facility that the sprinkler heads in the following locations exhibited signs of oxidation: 2nd Floor North - Housekeeping closet, and 1st Floor - RM 423. 3. On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during the tour of the facility that the sprinkler head located in the Kitchen walk-in cooler exhibited signs of loading of foreign debris. 4. On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during the tour of the facility that in the following locations had items placed and/or stacked closer than 18" to the sprinkler head: 2nf Floor North - corridor closet; 1st Floor - RM 139; 1st Floor - Dementia Care Unit - linen closet; 1st Floor - Office Area closet; 1st Floor - RM 184; 1st Floor - linen closet adjacent to Nurses Station An interview with the Maintenance Director	K 353	provide information to the Safety Committee. 2. Service Testing was completed on April 25th, 2023. Sprinkler heads that showed signs of oxidation were inspected and will be replaced. 3. Service Testing was completed on April 25th, 2023. Sprinkler heads that showed signs of debris were inspected and will be replaced. 4. The areas stated on the correction order have been removed. The removal of the top shelf in these locations were removed to stop the stacking of items close to the sprinkler system. Staff were educated at an All Staff Meeting in April the importance of not stacking linen or other items close to sprinkler heads. Plant Operations will do monthly audits to monitor clearances and will report to the Safety Committee.	

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K 353	Continued From page 6 verified this deficient finding at the time of discovery.	K 353		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		3/10/23

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K 918	Continued From page 7 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.5.4.1.1.2, and 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during documentation review that there was no evidence presented to confirm that the once every 36 months - 4 hour continuous run of the emergency generator is occurring. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 918	The 4-hour load bank test was completed on 3/10/2023 by Interstate Power Systems, 21568 Highview Ave. Lakeville MN 55044. 9522-854-5511. Plant Operations has a monthly checklist for testing the generator. The Plant Operations Director will do audits of the checklist twice a year. Plant Operations will schedule a load bank test for the generator within 34 months of last test date. See attachment	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920		4/28/23

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K 920	Continued From page 8 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables as-well-as listed and labeled equipment in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400-8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed by observation, that on the 1ST Floor, Office Area, a refrigerator was connected to relocatable power taps. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 920	The power strip was removed from the small appliance that was plugged into the wall in the front office. Staff was educated on not using power strips at the April All Staff Meeting. Monthly checks will be continued and will be monitored by the Safety Committee.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag	K 923		4/28/23

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K 923	Continued From page 9 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

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K 923	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.1, 11.6.2.3 (3). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed by observation that the Med Gas Storage Room (RM 138) was found to be unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	At the April All Staff meeting, staff were educated on the importance of locking the Oxygen Storage Room and that the storage room always needs to remain locked. The plant operations director will change out current locks to auto locking type by May 10th, 2023. The Oxygen Storage Rooms will be checked daily by station nurse to ensure they remain locked.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide documentation to confirm that staff are being	K 926	Educare was assigned to staff and documented on proper training of medical gases. These trainings will be completed	4/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	**201 SOUTH COUNTY ROAD 5** **SPRINGFIELD, MN 56087**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 11 trained and continuous education is occurring and documented related to the interface and administration of Med Gas (oxygen) per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/08/2023 between 10:00 AM and 3:00 PM, it was revealed during documentation review that there was no documentation presented to confirm that education and training associated to general administration of medical gases and cylinders, and continuing education is occurring. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 926	by May 15th, 2023. The Staff Development Director or designee will monitor for compliance.	