Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 11, 2023

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

RE: CCN: 245635
Cycle Start Date: March 9, 2023

Dear Administrator:

On April 12, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2023

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

Re: Reinspection Results
Event ID: CWMO12

Dear Administrator:

On April 12, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2023

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

RE: CCN: 245635
Cycle Start Date: March 9, 2023

Dear Administrator:

On March 9, 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 9, 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 9, 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
	245635	A. BUILDING _____ B. WING _____	C 03/09/2023

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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health on 03/06/23 to 03/09/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC in conjunction with the Minnesota Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/06/23 to 03/09/23 Survey Census: 53 Sample Size: 22 Supplemental Residents: 0 The following complaints were reviewed with no deficiency issued. H56358971C (MN00087235), H56359037C (MN00088401), H56359035C (MN00085187).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		3/31/23

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

Electronically Signed | 03/31/2023

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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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to promote a dignified dining experience for 1 of 1 resident (R17) reviewed for dignity in dining. Staff failed to offer or provide meal assistance to the resident,	F 550	F000 Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the	

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F 550	Continued From page 2 who was seated with another resident who was eating their meal. In addition, staff failed to provide promptly assistance and reapply the resident's nasal cannula. Findings include: Review of the facility's policy titled, The Person Centered Dining Approach, dated 2013, specified, "Each person is treated like a special individual, with focus on individualizing all interactions, interventions and care including food, nutrition and dining." R17's Admission Record, located in the resident's Electronic Medical Record (EMR), revealed R17 was admitted to the facility on 6/10/22, with diagnoses which included dementia and obstructive pulmonary disease. R17's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/22, located in the resident's EMR, specified the resident required set up help with eating and was able to make herself understood and being able to understand others. R17's care plan, provided by the facility staff, revealed a "Problem/Strength" area initiated on 06/07/22, that specified R17 had an "Alteration in thought processes." A goal specified R17 "Will have all needs anticipated and met daily." A care plan intervention directed all staff to "Anticipate/meet needs daily. Make every effort to bring resident to meals in the dining room and to activities." Continuous observation beginning on 03/06/23, at 5:25 p.m. revealed R17 was seated in the	F 550	correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. St. Johns on Fountain Lake has, and always will, assure each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified. R17 passed away on March 9, 2023. All other residents who need assistance with feeding have had their care plans reviewed and updated, if necessary, by March 16, 2023. No other residents are using continuous oxygen at the time of written plan of correction. Reviewed all other residents and updated care plans to assure it is documented that they use O2 on a PRN basis. The following policy and procedures were reviewed and updated on March 7, 2023: Feeding a resident, Feeding a dependent resident, and Person centered dining approach. The oxygen administration policy regarding checking resident□s oxygen tubing for proper placement was reviewed and updated on 3/30/2023 and nursing assistant orientation checklist was	

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F 550	Continued From page 3 second-floor dining room with her evening meal on the dining room table. On 03/06/23, at 5:26 p.m. nursing assistant (NA)-B was observed to offer R17 a couple bites of the meal and then walked away from the table. Observation on 03/06/23, at 5:34 p.m. revealed R17's nasal cannula fell from her nose. Observation on 03/06/23, at 5:39 p.m. revealed R17 was still not eating her meal when NA-X walked past her carrying bowl of soup for another resident and the NA-X appeared unaware R17's nasal cannula was not in place. Observation on 03/06/23, at 5:41 p.m. revealed R17 was still seated at the dining room table not eating her meal and holding her nasal cannula in her left hand as her tablemate continued to eat her meal. On 03/06/23 at 5:47 p.m., NA-W was observed to assist R17's tablemate, who had finished eating her meal, from the dining room. R17 was observed still seated at the dining room table not eating or being assisted by staff to eat her meal. Observation on 03/06/23, at 5:50 p.m. revealed R17 was reaching towards her food on the table but was unable to reach her food or eating utensils. At 5:51 p.m., registered nurse (RN)-A was asked if R17 needed assistance with eating. RN-A stated R17 could sometimes feed herself, and sometimes she needed assistance with eating her meal. Observation at 5:54 p.m., revealed RN-A walked over to R17 and asked if she wanted to eat anymore of her supper meal, and R17 replied, "Yes." RN-A was observed to reapply the resident's nasal cannula. At 5:55	F 550	updated to reflect policy updates on the same date. Training and education were immediately done with floor staff and continued through March 31, 2023. Auditing/monitoring of mealtimes, and proper placement of oxygen tubing will be done daily, M-F, for 12 weeks, then weekly thereafter for 3 months with results being reported to QAPI Committee.	

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F 550	Continued From page 4 p.m., RN-A sat next to R17 and started to feed her and R17 ate bites of pears. Observation on 03/06/23 at 6:07 p.m. revealed R17 continued to eat her meal slowly while being assisted by RN-A. When RN-A asked R17 if she was getting full the resident replied, "No." RN-A was observed to continue to feed R17 her evening meal. During an interview on 03/06/23, at 6:51 p.m. NA-B stated R17 had experienced a decline in condition over the past week to week and a half, and she had not been wanting to eat much. NA-B verified that during the evening meal of 03/06/23, she only offered R17 a couple bites of the meal, and then walked away before the resident finished her meal. NA-B explained that she should have sat down with R17 to provide her with assistance with her evening meal, but she got sidetracked with serving meal trays to other residents who were eating in their room. During an interview on 03/06/23, at 6:17 p.m., RN-A stated that staff should have recognized that R17 needed assistance with her meal and offered R17 prompting and cueing to eat, as well as assistance when needed. During an interview on 03/06/23 at 6:36 p.m., the director of nursing (DON) stated if a resident was not eating a meal, she would expect the staff to provide prompting, cueing, and find out if the resident needed assistance when eating.	F 550		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	F 698		3/31/23

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F 698	Continued From page 5 The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and facility policy review, the facility failed to coordinate services and make arrangements for the provision of meals for 1 of 1 resident (R16) reviewed for dialysis, when the resident was out of the facility to receive dialysis treatment. Findings include: Review of the facility's policy titled, Renal Diets, dated 2013, revealed, "The RD [Registered Dietitian] or designee will discuss the individual's needs with the dialysis RD, and request a copy of the dialysis daily meal plan/pattern, or refer to the facility's Diet/Nutrition Care Manual as appropriate." R16's Admission Record, provided by the facility, revealed R16 was admitted to the facility on 05/14/20, with diagnoses which included chronic kidney disease. R16's Physician Orders, located in the resident's electronic medical record (EMR), revealed current orders for R16 to receive hemodialysis three times per week and a renal diet. R16's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/05/23, located in the resident's EMR, specified the resident received dialysis. The resident had a "Brief Interview for Mental Status (BIMS)" score	F 698	St. John□s on Fountain Lake has, and always will, ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents□ goals and preferences. R16□s care plan was reviewed immediately and updated on March 16th, 2023. There are no other like residents that would be affected. Reviewed hemodialysis policy and procedure and dialysis contract/memo of understanding, with updates completed March 16, 2023. Training and education on policy and procedures with nursing and dining services was completed by March 31, 2023. DON or designee will audit/monitor food being provided to residents on dialysis daily, M-F, for 4 weeks, then weekly thereafter for 3 months, with results being reported to QAPI committee.	

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F 698	Continued From page 6 of 12/15, which indicated the resident had moderate cognitive impairment. R16's care plan, provided by the facility, revealed a "Problem/Strength" area initiated on 05/22/20, that specified R16 required dialysis related to renal failure. A care plan goal specified that R16 "Will be monitored for complications/infections. Will receive dialysis/diet/fluids/meds/Tx [treatment] per MD [physician] order." The care plan did not address how the facility was going to provide R16 with a lunch meal or meal alternative when she received dialysis treatments three times per week and was out of the facility from 10:00 a.m. to 3:00 p.m. During an interview on 03/07/23 at 9:57 a.m., R16 stated that she is transported to dialysis every Monday, Wednesday, and Friday. R16 explained that on the days she receives dialysis treatments, she eats breakfast at 9:00 a.m., leaves the facility to be transported to dialysis at 10:00 a.m., returns to the facility at around 3:00 p.m., and eats her evening meal at 5:30 p.m. R16 stated that she gets hungry on the days that she receives dialysis treatments because the facility does not provide lunch or any food for her to take to dialysis and she does not eat from 9:00 a.m. to 5:30 p.m., when she receives her evening meal. During an additional interview on 03/08/23 at 10:04 a.m., R16 stated that she was getting ready to go to dialysis. R16 stated she had a good breakfast, but the facility did not provide her with any food to take to dialysis. Observation on 03/08/23 at 10:15 a.m. revealed R16 was being assisted onto the transport van by the van driver for transport to dialysis. R16 was observed to not have any food to take with her to	F 698		

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F 698	Continued From page 7 the dialysis center. During an interview on 03/09/23 at 12:45 p.m., the dietary manager (DM) confirmed the dietary department did not provide R16 with any food to take to her dialysis treatments. The DM stated that she would communicate further with R16 and the dialysis center to develop a lunch meal plan for R16 for the three days per week when she receives dialysis treatments.	F 698		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure there was a Registered Nurse (RN) on duty for eight consecutive hours per day. This failure had the potential to affect resident assessments, care, and treatments for all the 53 residents in the facility. Findings include:	F 727	St. John□s on Fountain Lake has, and always will, ensure the use of a registered nurse for at least 8 hours consecutive hours, per day, 7 days a week. One day in a two-week schedule for nursing department was missing the required amount of eight hours for a registered nurse (RN).	3/31/23

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F 727	Continued From page 8 Review of the facility-provided daily staffing sheets for 02/26/23 through 03/11/23 revealed that on Sunday, 02/26/23, there was no RN scheduled to work that day on any shift. There were only Licensed Practical Nurses working on 02/26/23, the day that the facility failed to have an RN on duty for eight consecutive hours. During an interview on 03/08/23 at 4:30 p.m. the director of nursing (DON) confirmed, "There was no RN scheduled to work ...there was no RN coverage for 24-hours." Further interview with the DON revealed that, "Staffing is based against the facility assessment." A request was made for the DON to provide policies and procedures related to clinical staffing. In response, the DON referred to the facility assessment. Review of the undated, "St. John's on Fountain Lake Facility Assessment," document revealed that it failed to address the need for the facility to have an RN on duty for eight consecutive hours.	F 727	All nursing department staff were reviewed to determine the number of RN□s. Facility can staff 1 RN each day for 8 consecutive hours a day. Re-education with staffing coordinator and DON occurred on March 8th, 2023. Staffing meetings occur at least 3 times a week, and as needed, to review nursing department schedule and to verify there is 8 continuous hours of RN coverage each day. Audits and monitoring will be completed daily by the Administrator or designee, M-F, for 4 weeks and 1x weekly for 3 months thereafter with results being reported to QAPI.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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	F 812		3/31/23

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	245635	A. BUILDING _____ B. WING _____	C 03/09/2023

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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F 812	Continued From page 9 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 policy review, the facility failed to date bread products with an expiration date or "use by" date when they were removed from their original box, and to close bread packages prior to storage. This had the potential to affect all 53 residents who consumed bread products from the kitchen. Findings include: Review of the facility's policy titled, Food Storage, dated 2013, specified, "All foods should be covered, labeled and dated. All foods should be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded." 1. a. Observation during the initial kitchen inspection on 03/06/23 from 2:05 p.m. to 2:30 p.m., of food stored in the kitchen's reach-in freezer revealed 16 undated packages of hot dog buns, two undated packages of hamburger buns, and one undated package of cranberry bread. b. Observation during the initial kitchen inspection on 03/06/23 from 2:05 p.m. to 2:30 p.m., of food stored in one of the kitchen's reach-in refrigerators revealed 35 undated 24-ounce packages of sliced bread.	F 812	St. John□s on Fountain Lake has, and always will, procure foods from sources approved or considered satisfactory by federal, state or local authorities as well as store, prepare, distribute, and serve foods in accordance with professional standards for food service safety. Bread immediately was thrown out on 3/6/2023 and training and education was started on 3/7/2023. All other kitchenettes were reviewed on 3/7/2023 and 3/8/2023 for like situations. Policy and procedure for food storage was reviewed on 3/8/2023, with no changes required, by the dietician and dining services manager. Additional education regarding food storage and handling was completed by dietician on March 23, 2023. Nursing and dining services staff were trained and education was initiated on March 22, 2023 and continued through March 31, 2023. Auditing/monitoring started on 3/17/2023	

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F 812	Continued From page 10 Interview with the dietary manager (DM) on 03/06/23 at 2:15 p.m., revealed she was unable to determine the expiration dates of these undated packages of hotdog buns, hamburger buns, sliced bread, and cranberry bread. The DM stated the expiration date of the bread products was printed on their original box and staff should date the bread product when they remove it from the box. 2. Observation during the initial third-floor satellite kitchen inspection on 03/06/23 at 2:40 p.m., revealed a drawer that contained two undated 24-ounce packages of sliced bread that were very hard, one undated and opened package of hamburger buns, one undated and opened package of hot dog buns, and one undated and opened package of rolls. Interview with the DM on 03/06/23 at 2:50 p.m., revealed she was unable to determine the expiration dates of the undated packages of sliced bread, hamburger buns, hotdog buns and rolls stored in this drawer. The DM again explained the expiration date of a bread product is printed on its original box and staff should date the bread products when they are removed from its box. The DM also stated the opened packages of hamburger buns, hot dog buns and rolls should have been closed by staff before being stored in this drawer.	F 812	by dining services director or designee and will continue daily for 4 weeks, 3x week for 1 month, and weekly for 3 months with results being reported to QAPI.	
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality	F 868		3/31/23

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F 868	Continued From page 11 assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview, review of facility documentation, and review of facility policy, the Quality Assurance (QA) committee failed to ensure required members of the committee attended the quarterly meetings. This failure had	F 868	St. John□s on Fountain Lake has, and always will, maintain a quality assessment and assurance committee consisting of, at a minimum: the director of nursing, Medical Director or designee, three other	

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F 868	Continued From page 12 the potential to affect all 53 residents who currently resided in the facility. Findings include: Review of the facility sign-in log for the "Quality Assurance Meeting," dated 07/19/22 and held for the second quarter review, revealed the Medical Director failed to attend the meeting. Review of the facility sign-in log for the "Quality Assurance Meeting," dated 01/17/23 and held for the fourth quarter review, revealed both the Administrator and the Director of Nursing (DON) failed to attend the meeting. Review of the facility document titled, Quality Assurance and Performance Improvement [QAPI], dated 2021 [sic], revealed, "It is the facility policy to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, residents' quality of life and resident's choice and is based on the scope and complexity services defied by the Facility Assessment ...Procedure: 3. The facility maintains documentation and can demonstrate evidence that the program meets CMS (Center for Medicare and Medicaid) requirements. 5. The Quality Assessment and Assurance Committee consists at a minimum of: a. The director of nursing services; b. The Medical Director or his/her designee; c. At least three other members of the facility's staff, at least one of who must be the administrator (sic) ..." On 03/09/23 at 5:20 p.m., an interview with the administrator was conducted. During interview, the administrator stated "The QAPI committee meets quarterly and is attended by the medical	F 868	members of the facility□s team (administrator, owner, board member, or other individual in a leadership role), and the infection preventionist. QAPI policy and procedure was accurate and needed no updating upon review March 9, 2023 by the CEO/Administrator. St. John□s Lutheran Community will initiate monthly QAPI meetings to exceed the expectation of meeting quarterly and will assure all required participants are in attendance at least quarterly. The first monthly QA&A/QAPI committee was held on March 14th and on set dates, monthly moving forward. An audit to monitor attendance will be done by the administrator, or designee, 1x monthly for 6 months with results being reported to the board of directors to ensure compliance.	

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F 868	Continued From page 13 director, DON, administrator and department heads." When the sign-in logs were reviewed, the administrator confirmed, administrator and the DON failed to attend the 01/17/23 quarterly meeting. The Administrator also verified that the Medical Director failed to attend the 07/19/22 quarterly meeting.	F 868		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of cleaning lists, the facility failed to keep the oven and drawer, microwave oven, and refrigerator clean in the facility's third-floor satellite kitchen B. This failure had the potential to affect 14 residents who consumed food from this kitchen. Findings include: Review of the facility's undated cleaning list titled, Daily Dining Room Cleaning List, revealed, "All tasks are to be done after each meal." Tasks on the dining room cleaning list included; "Clean out microwave," "Refrigerator is to be clean inside and outside and restocked," and "AM (morning) shift needs to reset the oven (for cleaning) for 2 hours at the end of shift." 1. Observation made during the initial inspection of the facility's third-floor satellite kitchen B on 03/06/23 from 2:40 p.m. to 2:50 p.m., revealed the following:	F 921	St. Johns on Fountain Lake has, and always will, provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The oven and oven drawer (inner cooking compartment and inner door of kitchen oven) microwave oven, and refrigerator were cleaned in the facility's third-floor satellite kitchen B immediately on March 8, 2023. All other appliances in additional satellite kitchens were reviewed for cleanliness immediately and address if needed on March 8, 2023. Employee sanitary policy and procedure was reviewed by the dietician and dining services manager with no changes needed on March 9th, 2023.	3/31/23

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F 921	Continued From page 14 a. The inner cooking compartment and inner door of the kitchen oven was unclean with dried food spills. Additionally, the drawer under the oven was unclean, with accumulated loose dried food debris and dried food spills. b. The kitchen's microwave oven was unclean with dried food splatters in its inner cooking compartment. c. The kitchen's refrigerator was unclean with accumulated dried spills and sticky substances. 2. Additional observation of the facility's third-floor satellite kitchen B on 03/08/23 at 12:31 p.m., revealed the following: a. The microwave oven was unclean with dried food splatters in its inner cooking compartment. b. The kitchen's refrigerator was unclean with accumulated dried spills and sticky substances. During an interview on 03/08/23 at 12:31 p.m., the dietary manager (DM) stated that staff are expected to keep the equipment in the third-floor satellite kitchen B, including the oven, microwave, and refrigerator, clean.	F 921	Dietician and dining services manager initiated training and education on March 13, 2023 with the dining and nursing staff continuing through March 31, 2023. Auditing/monitoring started on March 17, 2023, by dining services director, or designee, and will continue daily for 4 weeks, 3x week for 1 month, and weekly for 3 months with results being reported to QAPI.	

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	245635	A. BUILDING **02** B. WING _____	**03/06/2023**

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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 03/06/2023. At the time of this survey, ST JOHNS ON FOUNTAIN LAKE 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		03/31/2023

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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	245635	A. BUILDING **02** B. WING _____	**03/06/2023**

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K 000	Continued From page 1	K 000		

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 ON FOUNTAIN LAKE is a 3 story building with partial basement.

The original building was constructed in 2014, a three-story building with a partial basement and was determined to be of Type II (111) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms,

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K 000	Continued From page 2 corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374	St. John□s on Fountain Lake has, and always will, maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code sections 19.3.7.8 and 8.5.4.1. Environmental Services Director (EVS) purchased smoke barrier gaskets from Grainger on March 13, 2023, installed on	3/31/23

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K 374	Continued From page 3 On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed during the tour of the facility, that upon testing of the smoke barrier door assemblies located on the 3rd and 2nd Floors, all exhibited an air-gap greater than 1/8" that would allow the passage of smoke. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 374	3rd and 2nd floor doors on March 23, 2023. There are no other like doors in the facility. Monthly door review will occur, starting March 31, 2023, and will continue indefinitely. Audits will be performed monthly by EVS Director, or designee, for three months to assure compliance with results being reported to QAPI to ensure compliance.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), section 6.3.2.2.1.3(A). This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 511	St. John□s on Fountain Lake has, and always will, secure electrical panels per NFPA 99 (2012 edition), section 6.3.2.2.1 (A). Electrical panels on 3rd floor, adjacent to the nurses station and 2nd floor, adjacent	3/31/23

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K 511	Continued From page 4 On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by observation that unsecured electrical panels, in readily accessible in resident corridors, were found in the following locations: 3rd FL - adjacent to the Nurses Station, and 2nd FL adjacent to the Nurses Station An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 511	to the nurses station were locked on March 8, 2023. All other electrical panels in the SNF were reviewed for being secured. Audits will be performed monthly by EVS Director, or designee, for three months to assure compliance with results being reported to QAPI to ensure compliance.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	K 541		3/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **02** B. WING _____	**03/06/2023**

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 541	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4.4, 9.5.2, and NFPA 82 (2009 edition), Standard on Incinerators and Waste and Linen Handling Systems and Equipment section 5.2.3.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by observation on the 3rd Floor, that the bio-hazard and laundry chute doors were found duct-taped in such a manner that the latching hardware was disabled. 2. On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by observation on the 2nd Floor, that the bio-hazard and laundry chute doors were missing hardware (latching pins) such that the doors would not latch and seal the chute. 3. On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by observation on the Basement level, that the discharge cute in bio-hazard chute room, was found to duct-taped in such a manner that the safety hardware would not operate properly. At time of discovery, Maintenance Director removed duct-tape and other materials to restore functionality of safety hardware. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	St. John□s on Fountain Lake has, and always will, maintain chute doors of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4.4, 9.5.2, and NFPA 82 (2009 edition, Standards on Incinerators and Waste and Linen Handling Systems and Equipment section 5.2.3.3.2.1. The biohazard and laundry chute doors on 3rd floor had duct-tape removed immediately, and pins replaced, so the latching hardware is working by end of day on March 6, 2023. The biohazard and laundry chute doors on 2nd floor were repaired on March 28, 2023. Audits will be performed monthly by EVS Director, or designee, for three months to assure compliance with results being reported to QAPI to ensure compliance.	

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 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by a review of available documentation, that no evidence was presented for review for 7 of the past 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	St. John□s on Fountain Lake has, and always will, conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1, 19.7.1.6. A fire drill was conducted on March 28, 2023 assuring variability in fire drill schedule. A new fire drill schedule was put in place to ensure expected and unexpected times under varying conditions, at least quarterly on each shift. Audits will be completed monthly by the EVS Director, or designee, monthly for six months with results reported to QAPI committee to ensure compliance.	3/31/23
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		3/31/23

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

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K 761	Continued From page 7 annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.15.2, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by a review of available documentation, that the documentation presented for review did not confirm the annual inspection and testing of assemblies. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	St. John□s on Fountain Lake has, and always will, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.15.2, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. All doors, and assemblies, were inspected immediately and completed by March 9, 2023. A plan was put in place by EVS Director to annually review all doors and assemblies in the SNF. Annual door and assembly inspection reports will be submitted to QAPI committee by EVS Director to ensure compliance.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		3/31/23

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K 920	Continued From page 8 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 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 implement relocatable power taps per 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 03/06/2023 between 0145 PM and 0500 PM, it was revealed by observation, that on the 3rd	K 920	St. John□s on Fountain Lake has, and always will, assure that it follows relocatable power taps standards as set forth by 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. The refrigerator was unplugged from power strip and plugged directly into the wall on March 7, 2023.	

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K 920	Continued From page 9 Floor, Activities Director Office, a refrigerator was connected to a relocatable power tap. An interview with the Maintenance Director verified this deficient findings at the time of discovery.	K 920	An inspection of all other rooms and offices was completed by March 28, 2023 to ensure no other appliances were plugged into power strips. Audits will be completed monthly of all offices and residents rooms to ensure compliance by EVS Director for three months with results being reported to QAPI committee.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag 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	K 923		3/31/23

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K 923	Continued From page 10 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) 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 11.6.2.3(11), 11.6.5.2 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/06/2023 between 1:45 PM and 5:00 PM, it was revealed by observation, that in the Med Gas Storage Room (Room 28), there were unsecured freestanding cylinders and no defined area of separation for empty/full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	St. John□s has, and always will, maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.2.3 (11), 11.6.5.2. Unsecured cylinders were removed on March 31, 2023 by the director of nursing and health unit coordinator. Oxygen equipment room was re-organized with signage to clearly indicate where to place full and empty cylinders on March 21, 2023. Policy and procedure related to oxygen equipment management and storage was updated with training and education done with nursing and maintenance staff by March 31, 2023, by the CEO/Administrator or designee. Audits will be completed 1x weekly for 1 month and monthly thereafter for three months by EVS Director, or designee, to ensure compliance with results being	

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K 923	Continued From page 11	K 923	reported to QAPI committee.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: CWMO11

Dear Administrator:

The above facility was surveyed on March 6, 2023 through March 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31639	A. BUILDING: _____ B. WING _____	C 03/09/2023

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

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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 3/06/23 to 3/09/23, 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. H56358971C (MN00087235), H56359037C (MN00088401), H56359035C (MN00085187). 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure there was a Registered Nurse (RN) on duty for eight consecutive hours per day. This failure had the potential to affect resident assessments, care, and treatments for all the 53 residents in the facility. Findings include: Review of the facility-provided daily staffing sheets for 02/26/23 through 03/11/23 revealed that on Sunday, 02/26/23, there was no RN scheduled to work that day on any shift. There were only Licensed Practical Nurses working on 02/26/23, the day that the facility failed to have an RN on duty for eight consecutive hours. During an interview on 03/08/23 at 4:30 p.m. the director of nursing (DON) confirmed, "There was	2 810	St. John□s on Fountain Lake has, and always will, ensure the use of a registered nurse for at least 8 hours consecutive hours, per day, 7 days a week. One day in a two-week schedule for nursing department was missing the required amount of eight hours for a registered nurse (RN). All nursing department staff were reviewed to determine the number of RN□s. Facility can staff 1 RN each day for 8 hours a day. Re-education with staffing coordinator and DONs regarding the expectation of scheduling at least 8 consecutive hours of RN coverage occurred on March 8th, 2023.	3/31/23

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2 810	Continued From page 3 no RN scheduled to work ...there was no RN coverage for 24-hours." Further interview with the DON revealed that, "Staffing is based against the facility assessment." A request was made for the DON to provide policies and procedures related to clinical staffing. In response, the DON referred to the facility assessment. Review of the undated, "St. John's on Fountain Lake Facility Assessment," document revealed that it failed to address the need for the facility to have an RN on duty for eight consecutive hours. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810	Staffing meetings occur at least 3 times a week, and as needed, to review nursing department schedule and to verify there is 8 hours of RN coverage each day. Audits and monitoring will be completed daily by the Administrator or designee, M-F, for 4 weeks and 1x weekly for 3 months thereafter with results being reported to QAPI.	
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by:	21665		3/31/23

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	31639	A. BUILDING: _____ B. WING _____	C 03/09/2023

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21665	Continued From page 4 Based on observation, interview, and review of cleaning lists, the facility failed to keep the oven and drawer, microwave oven, and refrigerator clean in the facility's third-floor satellite kitchen B. This failure had the potential to affect 14 residents who consumed food from this kitchen. Findings include: Review of the facility's undated cleaning list titled, Daily Dining Room Cleaning List, revealed, "All tasks are to be done after each meal." Tasks on the dining room cleaning list included; "Clean out microwave," "Refrigerator is to be clean inside and outside and restocked," and "AM (morning) shift needs to reset the oven (for cleaning) for 2 hours at the end of shift." 1. Observation made during the initial inspection of the facility's third-floor satellite kitchen B on 03/06/23 from 2:40 p.m. to 2:50 p.m., revealed the following: a. The inner cooking compartment and inner door of the kitchen oven was unclean with dried food spills. Additionally, the drawer under the oven was unclean, with accumulated loose dried food debris and dried food spills. b. The kitchen's microwave oven was unclean with dried food splatters in its inner cooking compartment. c. The kitchen's refrigerator was unclean with accumulated dried spills and sticky substances. 2. Additional observation of the facility's third-floor satellite kitchen B on 03/08/23 at 12:31 p.m., revealed the following: a. The microwave oven was unclean with dried food splatters in its inner cooking compartment.	21665	St. John□s on Fountain Lake has, and always will, provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Appliances immediately cleaned on March 8, 2023. Employee sanitary policy and procedure was reviewed by the dietician and dining services manager with no changes needed on March 9th, 2023. Dietician and dining services manager initiated training and education on March 13, 2023 with the dining and nursing staff continuing through March 31, 2023. Auditing/monitoring started on March 17, 2023, by dining services director, or designee, and will continue daily for 4 weeks, 3x week for 1 month, and weekly for 3 months with results being reported to QAPI.	

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21665	Continued From page 5 b. The kitchen's refrigerator was unclean with accumulated dried spills and sticky substances. During an interview on 03/08/23 at 12:31 p.m., the dietary manager (DM) stated that staff are expected to keep the equipment in the third-floor satellite kitchen B, including the oven, microwave, and refrigerator, clean. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional environment in kitchenette areas. The DON or designee, could coordinate with dietary, maintenance and housekeeping staff to conduct periodic audits of kitchenettes to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and review of	21805	F000	3/31/23

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21805	Continued From page 6 facility policy, the facility failed to promote a dignified dining experience for 1 of 1 resident (R17) reviewed for dignity in dining. Staff failed to offer or provide meal assistance to the resident, who was seated with another resident who was eating their meal. In addition, staff failed to provide promptly assistance and reapply the resident's nasal cannula. Findings include: Review of the facility's policy titled, The Person Centered Dining Approach, dated 2013, specified, "Each person is treated like a special individual, with focus on individualizing all interactions, interventions and care including food, nutrition and dining." R17's Admission Record, located in the resident's Electronic Medical Record (EMR), revealed R17 was admitted to the facility on 6/10/22, with diagnoses which included dementia and obstructive pulmonary disease. R17's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/22, located in the resident's EMR, specified the resident required set up help with eating and was able to make herself understood and being able to understand others. R17's care plan, provided by the facility staff, revealed a "Problem/Strength" area initiated on 06/07/22, that specified R17 had an "Alteration in thought processes." A goal specified R17 "Will have all needs anticipated and met daily." A care plan intervention directed all staff to "Anticipate/meet needs daily. Make every effort to bring resident to meals in the dining room and to activities."	21805	Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F550 St. John□s on Fountain Lake has, and always will, assure each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified. R17 passed away on March 9, 2023. All other residents who need assistance with feeding have had their care plans reviewed and updated, if necessary, by March 16, 2023. No other residents are using continuous oxygen at the time of written plan of correction. Reviewed all other residents and updated care plans to assure it is documented that they use O2 on a PRN basis. The following policy and procedures were reviewed and updated on March 7, 2023: Feeding a resident, Feeding a dependent resident, and Person centered dining approach. The oxygen administration policy	

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21805	Continued From page 7 Continuous observation beginning on 03/06/23, at 5:25 p.m. revealed R17 was seated in the second-floor dining room with her evening meal on the dining room table. On 03/06/23, at 5:26 p.m. nursing assistant (NA)-B was observed to offer R17 a couple bites of the meal and then walked away from the table. Observation on 03/06/23, at 5:34 p.m. revealed R17's nasal cannula fell from her nose. Observation on 03/06/23, at 5:39 p.m. revealed R17 was still not eating her meal when NA-X walked past her carrying bowl of soup for another resident and the NA-X appeared unaware R17's nasal cannula was not in place. Observation on 03/06/23, at 5:41 p.m. revealed R17 was still seated at the dining room table not eating her meal and holding her nasal cannula in her left hand as her tablemate continued to eat her meal. On 03/06/23 at 5:47 p.m., NA-W was observed to assist R17's tablemate, who had finished eating her meal, from the dining room. R17 was observed still seated at the dining room table not eating or being assisted by staff to eat her meal. Observation on 03/06/23, at 5:50 p.m. revealed R17 was reaching towards her food on the table but was unable to reach her food or eating utensils. At 5:51 p.m., registered nurse (RN)-A was asked if R17 needed assistance with eating. RN-A stated R17 could sometimes feed herself, and sometimes she needed assistance with eating her meal. Observation at 5:54 p.m., revealed RN-A walked over to R17 and asked if she wanted to eat anymore of her supper meal,	21805	regarding checking resident□s oxygen tubing for proper placement was reviewed and updated on 3/30/2023 and nursing assistant orientation checklist was updated to reflect policy updates on the same date. Training and education were immediately done with floor staff and continued through March 31, 2023. Auditing/monitoring of mealtimes, and proper placement of oxygen tubing will be done daily, M-F, for 12 weeks, then weekly thereafter for 3 months with results being reported to QAPI Committee.	

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21805	Continued From page 8 and R17 replied, "Yes." RN-A was observed to reapply the resident's nasal cannula. At 5:55 p.m., RN-A sat next to R17 and started to feed her and R17 ate bites of pears. Observation on 03/06/23 at 6:07 p.m. revealed R17 continued to eat her meal slowly while being assisted by RN-A. When RN-A asked R17 if she was getting full the resident replied, "No." RN-A was observed to continue to feed R17 her evening meal. During an interview on 03/06/23, at 6:51 p.m. NA-B stated R17 had experienced a decline in condition over the past week to week and a half, and she had not been wanting to eat much. NA-B verified that during the evening meal of 03/06/23, she only offered R17 a couple bites of the meal, and then walked away before the resident finished her meal. NA-B explained that she should have sat down with R17 to provide her with assistance with her evening meal, but she got sidetracked with serving meal trays to other residents who were eating in their room. During an interview on 03/06/23, at 6:17 p.m., RN-A stated that staff should have recognized that R17 needed assistance with her meal and offered R17 prompting and cueing to eat, as well as assistance when needed. During an interview on 03/06/23 at 6:36 p.m., the director of nursing (DON) stated if a resident was not eating a meal, she would expect the staff to provide prompting, cueing, and find out if the resident needed assistance when eating. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement systems to ensure	21805		

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21805	Continued From page 9 resident dignity is maintained. The DON or designee could educate all staff on these systems. Random audits for dignity could be done to ensure ongoing compliance. The DON or designee could review audit results with QAPI committee to determine need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		