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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DEYV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245407**

2. STATE VENDOR OR MEDICAID NO. (L2) **346740600**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/1/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 07/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/19/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245407

July 20, 2017

Mr. Joshua Jensen, Administrator
St. John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Dear Mr. Jensen:

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

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

Effective May 9, 2017 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2017

Mr. Joshua Jensen, Administrator
St. John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: Project Number S5407025

Dear Mr. Jensen:

On April 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 30, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 8, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 9, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 30, 2017, effective May 9, 2017 and therefore remedies outlined in our letter to you dated April 11, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 20, 2017

Mr. Joshua Jensen, Administrator
St. John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Re: Reinspection Results - Project Number S5407025

Dear Mr. Jensen:

On June 1, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 1, 2017, with orders received by you on April 11, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DEYV

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(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/30/2017** (L34)

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

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FISCAL YEAR ENDING DATE: (L35) **09/30**

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To (b) :

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

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

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

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 04/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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26. TERMINATION ACTION: (L30)
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02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 11, 2017

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: Project Number S5407025

Dear Mr. Jensen:

On March 30, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 9, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 9, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 30, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 _____	03/30/2017

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
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		5/9/17

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

Electronically Signed | 04/21/2017

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 _____	03/30/2017

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
F 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed rails met Food and Drug Administration (FDA) bed rail dimensional limits to prevent entrapment for 3 of 35 residents (R12, R29, R5) reviewed who utilized bed rails for bed mobility; failed to ensure the EZ-stand lift was used in accordance with the manufacturer's guidance for safe operation for 2 of 10 residents (R37, R70) who reside in the Riverhaven memory unit and required a stand lift for transfers and failed to ensure potentially hazardous chemicals were stored in a secure area and not accessible to all 14 residents located on the memory care Riverhaven unit. Findings include: R12's face sheet, dated 10/7/15 included diagnoses of osteoarthritis and peripheral neuropathy. The annual Minimum Data Set (MDS) assessment dated 11/27/16, indicated R12 required extensive assistance of two staff for bed mobility and transfers, and was cognitively intact. R12's bed rail assessment, last reviewed 12/27/16, indicated a top quarter (1/4) bed rail was located on both sides of the bed with the request originating from R12. This assessment for R12 indicated: (1) the bed rail was utilized whenever in bed, (2) did not prevent R12 from getting out of bed, (3) the mattress fit securely/snugly against the rails, (4) the rails were in good working order and (5) no history of R12 wedged between the bed rail and the mattress.	F 323	It is the policy of St. John Lutheran Home to maintain an accident free environment. Resident #5 and #12 will be assessed for their physical device needs, including bed rails and proper mattress fitting for the prevention of entrapment. Resident #29 is deceased. The facility has implemented a physical device assessment form to use on admission, quarterly, and/or a significant change in condition. The facility will conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment. Regarding standing lifts: An EZ stand lift safety checklist will be developed at attached to the lift to be used prior to each use. If the lift is out of compliance, the lift will be taken out of service and maintenance will be notified. The EZ stand audit will be conducted weekly for 4 weeks and incorporated into the monthly safety checklist. Regarding chemical storage: The orientation checklist for housekeeping will be updated to include the proper handling of chemicals, including that chemicals must be either in your possession or locked in the appropriate cabinet or housekeeping cart.	

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 _____	03/30/2017

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
F 323	Continued From page 2 During observation on 3/28/17, at 12:56 p.m. R12's bed had bilateral quarter bed rails. R12's bed rails were measured at this time and were noted to have a gap of 5" in Zones 2 and 4. During a follow up observation on 3/29/17, at 8:46 a.m. the Plant Operations Director (POD) verified R12's bed did not meet dimensional limits to prevent entrapment, and had a 5" gap in Zone 2 & 4. R29's face sheet, dated 6/13/16 included diagnoses of Alzheimer's disease and dementia. The significant change MDS assessment dated 3/13/17, indicated R29 required extensive assistance of two staff for bed mobility and transfers, and had severe cognitive impairment. R29's care plan dated 3/21/17, indicated she required extensive assistance of one to two staff for bed mobility; however, did not address utilization of the bed rail. R29's bed rail assessment dated 3/6/17, indicated a bed rail request originated from the resident and interdisciplinary care plan team. The bed rail assessment indicated: (1) a top quarter rail on both sides of the bed whenever R12 was in bed, (2) did not prevent R29 from getting out of bed, (3) the mattress fits securely/snugly against the rails, (4) rails are in good working order and (5) no history of R29 wedged between the bed rail and mattress. During observation on 3/27/17, at 1:41 p.m. R29 was utilizing a Hill-Rom electric bed, with bilateral quarter rails. R29's bed rails were noted to have a 7 3/4" long by 7 1/2" wide opening within the	F 323	Education will be provided to the housekeeping staff on the safety of handling and the storage of chemicals. Audits of the housekeeping carts will be conducted weekly for 4 weeks and monthly for 4 months, and randomly after that period. This will be included on the monthly safety checklist. The Director of Nursing, charge nurses, and the maintenance department will be responsible for maintaining compliance.	

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	245407	A. BUILDING _____ B. WING _____	03/30/2017

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railing in Zone 1 and a 5 1/2" gap in Zones 2 & 4. During follow up interview with the POD on 3/29/17, at 1:37 p.m. Zone 1 & 2 measurements were verified to exceed the bed rail entrapment dimensional limits. R29 was in bed at the time, with the railings raised. The measurement at this time in Zones 2 & 4 between the railing and mattress was 6 1/2".

The Guidance for Industry and FDA Staff - Hospital Bed System Dimensional Assessment and Guidance to Reduce Entrapment dated 3/10/06, identifies dimensional limit measurements to prevent entrapment injury as noted: Zone 1-within the rail, Zone 2-under the rail, between the rail supports or next to a single rail support, Zone 3-between the rail and the mattress and Zone 4-under the rail, at the ends of the rail. Dimensional limits are identified as a space no greater than 4 3/4" for Zones 1,2 &3, and no greater than 2 3/8" in Zone 4.

The facility's side rail review form, dated 6/2004 indicated side rails can be especially hazardous for demented or agitated individuals, who may be harmed by sliding between the rails or attempting to climb over them.

Standing lift usage
During observation on 3/27/17, at 9:24 a.m. an EZ-stand lift (a type of mechanical lift that utilizes a harness which goes around the resident's waist and is buckled, and is attached to the lift machine via two straps running underneath the resident's arms) was noted in an alcove located near the nursing station on the Riverhaven unit. The lift was noted to be missing safety catches at the end of the lift arms.

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R37's face sheet dated 12/11/15, identified current diagnoses of unspecified dementia without behavioral disturbance, frequent falls and osteoarthritis.

R37's quarterly MDS dated 1/16/17, identified she required extensive assistance of two staff for transfers and had moderate cognitive impairment. The care plan dated 1/24/17, indicated R37 extensive assistance of one to two staff with transfers or the EZ-stand lift. The transfer and mobility assessment dated 10/19/16, identified R37 could bear at least 50% of her weight with transfers, required physical assist of one to two staff for transfers and the EZ-stand lift as needed.

During observation on 3/29/17, at 8:02 a.m. R37 was observed being transferred in the EZ-stand lift by nursing assistants (NA)-A and NA-B. NA-A and NA-B secured the harness around R37's waist and attached the harness straps to the lift by slipping them over the hooks on the lift arms. The EZ-stand lift was noted to be missing the safety catches located at the end of the lift arms. R37 was raised from her wheelchair by the hydraulic lift and transported into the bathroom adjacent to the commons area. At 8:07 a.m., NA-A and NA-B wheeled R37 out of the bathroom. With R37 still attached in the EZ-lift while in a standing position, they transported the EZ stand-lift across the room to the commons area. R37 was then transferred into a recliner. The safety catches were noted to remain missing from the EZ-stand throughout both transfer observations.

During interview on 3/29/17, at 8:08 a.m. NA-B stated the safety catchers were "probably needed," when transferring a resident with the

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EZ-stand to ensure the harness did not fall off the lift. NA-B retrieved the safety catches out of a bag attached to the front of the lift and applied them to the ends of the EZ-stand arms. NA-B stated they popped off easily when the harnesses were removed from the lift after transferring the resident. NA-A was present at this time and confirmed the safety catches were supposed to be used; however, also agreed they popped off the equipment frequently.

When interviewed on 3/29/17, at 8:39 a.m. the director of nursing (DON) stated the safety catches should be utilized on the EZ-stand lift for all resident transfers. The plant operations director (POD) was present at this time and stated he checked the lifts on a quarterly basis to ensure they were functioning properly, and was aware the safety catches sometimes came off.

R70's diagnoses report dated 3/14/17, indicated diagnoses including Alzheimer's disease and dementia. R70 had recently been admitted and did not have a current MDS yet on file. The care plan dated 3/13/17, indicated R70 required extensive assistance of 1-2 staff to transfer on and off the toilet with the EZ stand lift.

R70's transfer and mobility assessment dated 3/16/17, did not identify a mechanical lift was required for transfers but identified R70 was able to bear at least 50% of his weight with transfers.

During observation on 3/30/17, at 10:37 a.m. R70 was hooked up to an EZ-stand lift in the commons area, in front of the adjacent bathroom. NA-A and NA-B engaged the hydraulic lift to raise R70 up in the EZ-stand for transfer. However, the safety clips were not in place. The surveyor

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intervened at this time and inquired whether the safety clips should be used to safely transfer R70. NA-A explained the safety clips were "off already this morning," and she had not ever reported her concerns related to the clips coming off to maintenance nor to the DON. NA-A proceeded to immediately attach the safety clips. She grabbed them from the bag located on the front of the EZ-stand lift and applied the clips appropriately. After application, she assisted R70 into the bathroom with the use of the EZ-stand lift.

During a telephone interview on 3/30/17, at 11:03 a.m. a representative from EZ-Way service department (E)-A stated the safety clips needed to be installed at all times when lifting residents in the standing lift for transfers. E-A verified the clips prevented the lift sling from slipping off the EZ-stand.

When interviewed on 3/30/17, at 11:11 a.m. the DON stated she was not aware of any falls from the EZ-stand lifts during the past year and indicated she thought maintenance had replaced the safety clips on the equipment (EZ-stand) on 3/29/17. Review of incident reports did not reveal any resident injuries or falls related to the EZ-stand.

NA-A's employee training file revealed she had been trained on proper use of the EZ-stand on 6/10/14. The performance criteria consisted of 30 steps and included: Item 18-Verify the loops are properly hooked on the lift arms and the Safety Catch is in place.

NA-B's employee training file revealed she had been trained on proper use of the EZ-stand lift on 3/19/15, including Item 18.

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The facility policy entitled St. John Lutheran Home Safe Patient Handling and Movement Policy, last revised 3/16 indicated employees were to notify their supervisor or the plant operations department of lifting devices in need of repair. In addition, the policy indicated station staff will use lifting devices and patient handling aids properly.

The EZ stand operating instructions last revised 3/11/09, indicated the harness loops were to be applied around the pigtail ends of the lift arms, and to ensure the safety catches were in place to prevent the harness loops from exiting the pigtail ends during patient transfer.

Chemical Storage
During observation of the Riverhaven unit (a secured memory care wing which housed 14 cognitively impaired individuals with wandering tendencies) on 3/27/2017 at 9:26 a.m. a bottle of Clorox Urine Remover, a half gallon of unidentified clear substance in an old milk jug and approximately 16 ounces of another clear substance in an unlabeled spray bottle was noted sitting on an unattended housekeeping cart near the nursing station. The cart was not in direct observation/eyesight of nursing nor housekeeping staff.

During a follow-up observation on 3/28/17, at 12:35 p.m. the housekeeping cart was again noted to be unlocked and not in direct view of nursing nor housekeeping staff. A half gallon jug of clear liquid in an old milk jug, a spray bottle and Clorox Urine Remover were stored on the cart. When interviewed on 3/28/17, at 12:35 p.m. housekeeper (H)-A stated the chemicals were

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identified as: Virex II 256 (a sanitizing agent) in the milk jug and the spray bottle contained Ecolab Disinfectant 2.0 which was stored in the soiled utility room. H-A confirmed the bottle of Clorox Urine Remover contained this identified cleaning solution and was noted to have approximately 16 oz of fluid remaining in the bottle. The dispenser of Ecolab Disinfectant 2.0 was then observed in the soiled utility with the presence of H-A. A label on the wall above the container stated, "Do not drink." H-A stated she must've been in a room yesterday when the cart was observed unattended and unsecured, and stated "We usually lock it up."

During observation on 3/29/17, at 7:32 a.m. the soiled utility room (Room 185) located in the Riverhaven unit did not have a locking door. Observation of the interior revealed a large gallon jug of Virex 256 on the floor, as well as a bottle of Extraction Rise spray.

When interviewed on 3/29/17, at 8:39 a.m. the plant operations director (POD) verified hazardous chemicals should be locked up when not in use and was unaware the soiled utility room door in room 185 did not have a lock.

The safety data sheet (SDS) for Virex II 256, dated 8/3/11, indicated primary routes of exposure as eye contact, skin contact and inhalation. It further indicated this chemical could be irritating to the mucosa of the stomach, mouth and throat upon ingestion and could cause corrosive effects to the respiratory tract with inhaled exposure.

The SDS for Disinfectant 2.0, dated 3/27/13, indicated the chemical had potential to cause

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serious eye irritation with contact and was toxic to the skin.

The SDS for Clorox Urine Remover, dated 1//5/15, indicated the chemical could cause stinging and irritation of the eyes.

A facility policy related to locking of hazardous chemicals was requested, none was provided.

R5's annual MDS dated 1/1/7, identified a BIMS score of 7, indicating moderately impaired cognition. It indicated R5 required extensive assistance with all activities of daily living (ADL's) with 1-2 staff and was unsteady when transferring and standing.

The falls Care Area Assessment (CAA) dated 1/5/17, identified R5 at risk due to weakness, balance problem, medications and diagnoses. The bed rail review form dated 1/1/17, identified R5 requested the use of the side rails; upper half of the bed with quarter bed rails (bilateral). The review identified: (1) R5 used the rails whenever in bed, (2) did not restrict R5 from exiting the bed, (3) the mattress fit snugly, (4) rails were in good working order and (5) no incidents of attempts made by R5 to crawl over/out or entanglement in past 6 months. No history of rolling from side lying into a position where R5 became wedged between side rail and mattress was documented.

When interviewed on 3/27/17, at 1:38 p.m. registered nurse (RN)-A stated R5 had rails attached to the bed to assist with turning and repositioning.

During initial observation of R5's room on 3/27/17, at 2:15 p.m. it was noted R5 had 1/4

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F 323	Continued From page 10 (one-quarter) bilateral bed rails located on the upper sides of the bed. The rails were noted to have a wide space between the top of the bed rails and the head of the bed and between the mattress and the bed rails. On 3/29/17 at 8:46 a.m. the POD entered R's room with surveyor to measure the spacing of the bed rails attached to the bed. The top of the rail to the headboard measured 7 inches. The distance between the mattress and the bed rail could range from 0-9 inches depending how far towards the wall the mattress was moved. It was noted the mattress slid, leaving a large space between the mattress and frame. The POD sated he was aware there were FDA requirements to prevent entrapment but was unsure of these requirements. The spacing between the mattress and the bed rail was greater than the recommended 4 3/4 inches as noted in the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10th 2006. The FDA also identified in the document that the spacing between the headboard of the bed and the top of the rails should be assessed for wide spacing.	F 323		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. John's Lutheran Home was found not to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2017

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 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: The original building was built in 1961 and was determined to be of Type II(000) construction; The 1st Addition was built in 1972 and was determined to be of Type II(000) construction; The 2nd Addition was built in 1987 and was determined to be of Type II(222) construction; The 3rd Addition was built in 1991 and was determined to be of Type II(222) construction, with a portion of the Addition being of Type V(111) construction; The 4th Addition was built in 2000 and was determined to be of Type III(211) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has	K 000		

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K 000	Continued From page 2 automatic smoke detectors in all Resident Rooms. The facility has a capacity of 85 beds and had a census of 77 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		5/5/17

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K 321	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain hazardous areas are protected by a fire barrier having 1-hour fire resistance rating. This deficiency could effect 25 of the 77 residents. Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) FINDINGS INCLUDE:	K 321	The door closer for the soiled utility room door 307-B has been adjusted so the door positively latches into the door frame. Ongoing compliance will be maintained by the plant operations department with routine checks of fire barriers to ensure they positively latch into the door frames.	

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 _____	**03/28/2017**

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 321	Continued From page 4 On facility tour between 9:00 AM and 1:00 PM on 03/28/2017, observation revealed the Soiled Utility Door (307-B) did not not positively latch into the door frame. This deficient practice was verified by the Facility Maintenance Director.	K 321		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing 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 STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 77 out of 77 residents.	K 353	St. John Lutheran Home will contract for quarterly scheduled sprinkler tests per the NFPA 101 sprinkler system testing guidelines. Ongoing compliance will be monitored by the Plant Operations Director.	5/5/17

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K 353	Continued From page 5 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 FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:00 PM on 3/28/2017, observation revealed that documentation could not be located to indicate that the quarterly fire sprinkler inspection had taken place in 2016. This deficient practice was verified by the Facility Maintenance Director.	K 353		

Electronically submitted
April 11, 2017

Mr. Joshua Jensen, Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5407025

Dear Mr. Jensen:

The above facility was surveyed on March 27, 2017 through March 30, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	03/30/2017

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

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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: 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: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On March 27, 28, 29 and 30, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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: Based on observation, interview and document review, the facility failed to ensure bed rails met Food and Drug Administration (FDA) bed rail dimensional limits to prevent entrapment for 3 of 35 residents (R12, R29, R5) reviewed who utilized bed rails for bed mobility. The facility also failed to ensure the EZ-stand lift was utilized in accordance with the manufacturer's guidance for safe operation for 2 of 10 residents (R37, R70) who reside in the Riverhaven unit and required a standing lift for transfers and failed to ensure potentially hazardous chemicals were stored in a secure area, inaccessible to all 14 residents located on the secure memory care Riverhaven unit. Findings include: R12's face sheet, dated 10/7/15 included diagnoses of osteoarthritis and peripheral neuropathy. The annual Minimum Data Set (MDS) assessment dated 11/27/16, indicated R12 required extensive assistance of two staff for bed mobility and transfers, and was cognitively intact.	21665	Corrected	5/9/17

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21665	Continued From page 3 R12's bed rail assessment, last reviewed 12/27/16, indicated a top quarter (1/4) bed rail was located on both sides of the bed with the request originating from R12. This assessment for R12 indicated: (1) the bed rail was utilized whenever in bed, (2) did not prevent R12 from getting out of bed, (3) the mattress fit securely/snugly against the rails, (4) the rails were in good working order and (5) no history of R12 wedged between the bed rail and the mattress. During observation on 3/28/17, at 12:56 p.m. R12's bed had bilateral quarter bed rails. R12's bed rails were measured at this time and were noted to have a gap of 5" in Zones 2 and 4. During a follow up observation on 3/29/17, at 8:46 a.m. the Plant Operations Director (POD) verified R12's bed did not meet dimensional limits to prevent entrapment, and had a 5" gap in Zone 2 & 4. R29's face sheet, dated 6/13/16 included diagnoses of Alzheimer's disease and dementia. The significant change MDS assessment dated 3/13/17, indicated R29 required extensive assistance of two staff for bed mobility and transfers, and had severe cognitive impairment. R29's care plan dated 3/21/17, indicated she required extensive assistance of one to two staff for bed mobility; however, did not address utilization of the bed rail. R29's bed rail assessment dated 3/6/17, indicated a bed rail request originated from the resident and interdisciplinary care plan team. The bed rail assessment indicated: (1) a top	21665		

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21665	Continued From page 4	21665		

quarter rail on both sides of the bed whenever R12 was in bed, (2) did not prevent R29 from getting out of bed, (3) the mattress fits securely/snugly against the rails, (4) rails are in good working order and (5) no history of R29 wedged between the bed rail and mattress.

During observation on 3/27/17, at 1:41 p.m. R29 was utilizing a Hill-Rom electric bed, with bilateral quarter rails. R29's bed rails were noted to have a 7 3/4" long by 7 1/2" wide opening within the railing in Zone 1 and a 5 1/2" gap in Zones 2 & 4. During follow up interview with the POD on 3/29/17, at 1:37 p.m. Zone 1 & 2 measurements were verified to exceed the bed rail entrapment dimensional limits. R29 was in bed at the time, with the railings raised. The measurement at this time in Zones 2 & 4 between the railing and mattress was 6 1/2".

R5's annual MDS dated 1/1/7, identified a BIMS score of 7, indicating moderately impaired cognition. It indicated R5 required extensive assistance with all activities of daily living (ADL's) with 1-2 staff and was unsteady when transferring and standing.

The falls Care Area Assessment (CAA) dated 1/5/17, identified R5 at risk due to weakness, balance problem, medications and diagnoses. The bed rail review form dated 1/1/17, identified R5 requested the use of the side rails; upper half of the bed with quarter bed rails (bilateral). The review identified: (1) R5 used the rails whenever in bed, (2) did not restrict R5 from exiting the bed, (3) the mattress fit snugly, (4) rails were in good working order and (5) no incidents of attempts made by R5 to crawl over/out or entanglement in past 6 months. No history of rolling from side lying into a position where R5 became wedged

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21665	Continued From page 5 between side rail and mattress was documented. When interviewed on 3/27/17, at 1:38 p.m. registered nurse (RN)-A stated R5 had rails attached to the bed to assist with turning and repositioning. During initial observation of R5's room on 3/27/17, at 2:15 p.m. it was noted R5 had 1/4 (one-quarter) bilateral bed rails located on the upper sides of the bed. The rails were noted to have a wide space between the top of the bed rails and the head of the bed and between the mattress and the bed rails. On 3/29/17 at 8:46 a.m. the POD entered R's room with surveyor to measure the spacing of the bed rails attached to the bed. The top of the rail to the headboard measured 7 inches. The distance between the mattress and the bed rail could range from 0-9 inches depending how far towards the wall the mattress was moved. It was noted the mattress slid, leaving a large space between the mattress and frame. The POD sated he was aware there were FDA requirements to prevent entrapment but was unsure of these requirements. The Guidance for Industry and FDA Staff - Hospital Bed System Dimensional Assessment and Guidance to Reduce Entrapment dated 3/10/06, identifies dimensional limit measurements to prevent entrapment injury as noted: Zone 1-within the rail, Zone 2-under the rail, between the rail supports or next to a single rail support, Zone 3-between the rail and the mattress and Zone 4-under the rail, at the ends of the rail. Dimensional limits are identified as a space no greater than 4 3/4" for Zones 1,2 &3, and no greater than 2 3/8" in Zone 4.	21665		

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21665	Continued From page 6 The facility's side rail review form, dated 6/2004 indicated side rails can be especially hazardous for demented or agitated individuals, who may be harmed by sliding between the rails or attempting to climb over them. Standing lift usage During observation on 3/27/17, at 9:24 a.m. an EZ-stand lift (a type of mechanical lift that utilizes a harness which goes around the resident's waist and is buckled, and is attached to the lift machine via two straps running underneath the resident's arms) was noted in an alcove located near the nursing station on the Riverhaven unit. The lift was noted to be missing safety catches at the end of the lift arms. R37's face sheet dated 12/11/15, identified current diagnoses of unspecified dementia without behavioral disturbance, frequent falls and osteoarthritis. R37's quarterly MDS dated 1/16/17, identified she required extensive assistance of two staff for transfers and had moderate cognitive impairment. The care plan dated 1/24/17, indicated R37 extensive assistance of one to two staff with transfers or the EZ-stand lift. The transfer and mobility assessment dated 10/19/16, identified R37 could bear at least 50% of her weight with transfers, required physical assist of one to two staff for transfers and the EZ-stand lift as needed. During observation on 3/29/17, at 8:02 a.m. R37 was observed being transferred in the EZ-stand lift by nursing assistants (NA)-A and NA-B. NA-A and NA-B secured the harness around R37's waist and attached the harness straps to the lift by slipping them over the hooks on the lift arms.	21665		

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21665	Continued From page 7 The EZ-stand lift was noted to be missing the safety catches located at the end of the lift arms. R37 was raised from her wheelchair by the hydraulic lift and transported into the bathroom adjacent to the commons area. At 8:07 a.m., NA-A and NA-B wheeled R37 out of the bathroom. With R37 still attached in the EZ-lift while in a standing position, they transported the EZ stand-lift across the room to the commons area. R37 was then transferred into a recliner. The safety catches were noted to remain missing from the EZ-stand throughout both transfer observations. During interview on 3/29/17, at 8:08 a.m. NA-B stated the safety catchers were "probably needed," when transferring a resident with the EZ-stand to ensure the harness did not fall off the lift. NA-B retrieved the safety catches out of a bag attached to the front of the lift and applied them to the ends of the EZ-stand arms. NA-B stated they popped off easily when the harnesses were removed from the lift after transferring the resident. NA-A was present at this time and confirmed the safety catches were supposed to be used; however, also agreed they popped off the equipment frequently. When interviewed on 3/29/17, at 8:39 a.m. the director of nursing (DON) stated the safety catches should be utilized on the EZ-stand lift for all resident transfers. The plant operations director (POD) was present at this time and stated he checked the lifts on a quarterly basis to ensure they were functioning properly, and was aware the safety catches sometimes came off. R70's diagnoses report dated 3/14/17, indicated diagnoses including Alzheimer's disease and dementia. R70 had recently been admitted and	21665		

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21665	Continued From page 8	21665		

did not have a current MDS yet on file. The care plan dated 3/13/17, indicated R70 required extensive assistance of 1-2 staff to transfer on and off the toilet with the EZ stand lift.

R70's transfer and mobility assessment dated 3/16/17, did not identify a mechanical lift was required for transfers but identified R70 was able to bear at least 50% of his weight with transfers.

During observation on 3/30/17, at 10:37 a.m. R70 was hooked up to an EZ-stand lift in the commons area, in front of the adjacent bathroom. NA-A and NA-B engaged the hydraulic lift to raise R70 up in the EZ-stand for transfer. However, the safety clips were not in place. The surveyor intervened at this time and inquired whether the safety clips should be used to safely transfer R70. NA-A explained the safety clips were "off already this morning," and she had not ever reported her concerns related to the clips coming off to maintenance nor to the DON. NA-A proceeded to immediately attach the safety clips. She grabbed them from the bag located on the front of the EZ-stand lift and applied the clips appropriately. After application, she assisted R70 into the bathroom with the use of the EZ-stand lift.

During a telephone interview on 3/30/17, at 11:03 a.m. a representative from EZ-Way service department (E)-A stated the safety clips needed to be installed at all times when lifting residents in the standing lift for transfers. E-A verified the clips prevented the lift sling from slipping off the EZ-stand.

When interviewed on 3/30/17, at 11:11 a.m. the DON stated she was not aware of any falls from the EZ-stand lifts during the past year and indicated she thought maintenance had replaced

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	00045	A. BUILDING: _____ B. WING _____	03/30/2017

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) COMPLETE DATE
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the safety clips on the equipment (EZ-stand) on 3/29/17. Review of incident reports did not reveal any resident injuries or falls related to the EZ-stand.

NA-A's employee training file revealed she had been trained on proper use of the EZ-stand on 6/10/14. The performance criteria consisted of 30 steps and included: Item 18-Verify the loops are properly hooked on the lift arms and the Safety Catch is in place.

NA-B's employee training file revealed she had been trained on proper use of the EZ-stand lift on 3/19/15, including Item 18.

The facility policy entitled St. John Lutheran Home Safe Patient Handling and Movement Policy, last revised 3/16 indicated employees were to notify their supervisor or the plant operations department of lifting devices in need of repair. In addition, the policy indicated station staff will use lifting devices and patient handling aids properly.

The EZ stand operating instructions last revised 3/11/09, indicated the harness loops were to be applied around the pigtail ends of the lift arms, and to ensure the safety catches were in place to prevent the harness loops from exiting the pigtail ends during patient transfer.

Chemical Storage
During observation of the Riverhaven unit (a secured memory care wing which housed 14 cognitively impaired individuals with wandering tendencies) on 3/27/2017 at 9:26 a.m. a bottle of Clorox Urine Remover, a half gallon of unidentified clear substance in an old milk jug and approximately 16 ounces of another clear

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substance in an unlabeled spray bottle was noted sitting on an unattended housekeeping cart near the nursing station. The cart was not in direct observation/eyesight of nursing nor housekeeping staff.

During a follow-up observation on 3/28/17, at 12:35 p.m. the housekeeping cart was again noted to be unlocked and not in direct view of nursing nor housekeeping staff. A half gallon jug of clear liquid in an old milk jug, a spray bottle and Clorox Urine Remover were stored on the cart. When interviewed on 3/28/17, at 12:35 p.m. housekeeper (H)-A stated the chemicals were identified as: Virex II 256 (a sanitizing agent) in the milk jug and the spray bottle contained Ecolab Disinfectant 2.0 which was stored in the soiled utility room. H-A confirmed the bottle of Clorox Urine Remover contained this identified cleaning solution and was noted to have approximately 16 oz of fluid remaining in the bottle. The dispenser of Ecolab Disinfectant 2.0 was then observed in the soiled utility with the presence of H-A. A label on the wall above the container stated, "Do not drink." H-A stated she must've been in a room yesterday when the cart was observed unattended and unsecured, and stated "We usually lock it up."

During observation on 3/29/17, at 7:32 a.m. the soiled utility room (Room 185) located in the Riverhaven unit did not have a locking door. Observation of the interior revealed a large gallon jug of Virex 256 on the floor, as well as a bottle of Extraction Rise spray.

When interviewed on 3/29/17, at 8:39 a.m. the plant operations director (POD) verified hazardous chemicals should be locked up when not in use and was unaware the soiled utility room

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21665	Continued From page 11 door in room 185 did not have a lock. The safety data sheet (SDS) for Virex II 256, dated 8/3/11, indicated primary routes of exposure as eye contact, skin contact and inhalation. It further indicated this chemical could be irritating to the mucosa of the stomach, mouth and throat upon ingestion and could cause corrosive effects to the respiratory tract with inhaled exposure. The SDS for Disinfectant 2.0, dated 3/27/13, indicated the chemical had potential to cause serious eye irritation with contact and was toxic to the skin. The SDS for Clorox Urine Remover, dated 1//5/15, indicated the chemical could cause stinging and irritation of the eyes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment, as well as the importance of ensuring chemicals are secured when not in use. Additionally, the DON or designee could ensure all staff are properly educated related to the safe operation and usage of all mechanical lifts in the facility, as well as conduct audits to ensure staff are operating them in accordance with manufacturer's instructions. The DON or designee, could audit resident side rails to ensure they meet Food and Drug Administration recommendations to prevent entrapment, and audit side rail assessments to ensure they are accurate and reflect the current condition of the equipment. The DON could report findings to the quality assurance committee for further recommendations to ensure ongoing compliance.	21665		

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21665	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		