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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DVZN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245338**

2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/06/2020** (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 **79** (L18)
13.Total Certified Beds **79** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 11/16/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/16/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
08/01/1986
(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
11/04/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2020

CMS Certification Number (CCN): 245338

Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

Dear Administrator:

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

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

Effective October 23, 2020 the above facility is certified for:

79 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 79 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2020

Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

RE: CCN: 245338
Cycle Start Date: September 18, 2020

Dear Administrator:

On October 9, 2020, we notified you a remedy was imposed. On November 6, 2020 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 23, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 8, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 9, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 23, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DVZN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00138

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2.STATE VENDOR OR MEDICAID NO.
(L2) **079040100**

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(L3) **ST JOHNS LUTHERAN HOME**
(L4) **901 LUTHER PLACE**
(L5) **ALBERT LEA, MN** (L6) **56007**

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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 **09/18/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	79			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 10/28/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/02/2020 (L20)

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

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

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(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

Electronically delivered
October 9, 2020

Administrator
St Johns Lutheran Home
901 Luther Place
Albert Lea, MN 56007

RE: CCN: 245338
Cycle Start Date: September 18, 2020

Dear Administrator:

On September 18, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 8, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 8, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 8, 2020.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only

if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by November 8, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Johns Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 8, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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:

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	C 09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE 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 survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 9/14/20 through 9/17/20, during a recertification survey. The facility is in full compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 9/14//20, through 9/18/20, a standard recertification survey was conducted at your facility. In addition, a COVID-19 survey and complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey: H#5338045C H#5338046C H#5338047C H#5338048C H#5338049C The following complaints were found to be unsubstantiated: H#5338044C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/15/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	C 09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Upon receipt of an acceptable electronic 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a call light the resident was physically able to use for 1 of 1 resident (R17) reviewed for reasonable accommodation of needs. Findings include: According to facesheet printed 9/15/20, R17's diagnoses included hypertensive heart disease, major depression, anxiety disorder, weakness, polyarthrisis (arthritis that affects five or more joints simultaneously), deformity of both hands due to osteoarthritis. R17's quarterly Minimum Data Set (MDS) assessment dated 7/21/20, indicated R17 was cognitively intact, had moderate difficulty hearing, moderately impaired vision, clear speech, was understood and could usually understand. R17 was totally dependent on staff for bed mobility, transfers, eating, toileting and personal hygiene.	F 558	F558 Corrective action for those residents affected On 9/17/2020 the Administrator met with Resident 17 (R17) to ask if she was able to use call light appropriately. R17 was not able to turn on call light due to contractures. On 9/17/2020 the facility provided R17 with a call light pad that she was able to use appropriately. On 9/21/2020 facility provided R17 with a soft touch call light pad that she was able to use appropriately. A referral to Occupation Therapy to evaluate and treat R17 was filled out on 9/21/2020. Identify other residents Residents with hand contractures, or other upper-extremity mobility deficits,	10/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING _____ B. WING _____	C 09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2 R17's care plan printed 9/15/20, indicated an alteration in thought process related to depression and anxiety in which R17 continued to yell out for assistance rather than using call light. Furthermore, the care plan identified R17 had deformity and contractures (fixed tightening of muscle, tendon and ligaments which prevents normal movement) of both hands related to arthritis. The care plan did not have an intervention for R17's inability to utilize her call light due to contractures. During an interview on 9/15/20, 2:38 p.m. nursing assistant (NA)-F stated R17 yelled for help if she needed something which was why her room was close to nurses desk. NA-F stated the small gray rubber ball (call light) was sensitive; "you just touch it and it would go off." During an interview and observation on 9/15/20, at 3:00 p.m., R17 was asked if she was able to squeeze or press down on the gray call light bulb. R17 tried, but was not able to lift her contracted hands and place them on top of the bulb to press down on it. During an interview on 9/16/20, at 10:55 a.m. physical therapy aide (PTA)-I stated she was unaware R17 was not able to use her call light. PTA-I stated the nurse practitioner would just need to write an order for an occupational therapy referral and they could look at it; "there are a whole bunch of different kinds of things we could try." During an interview on 9/16/20, 12:52 p.m. NA-B stated R17 was not able to drink fluids from the cup in her room on her own because "she can't	F 558	have the potential to be impacted by the alleged deficient practice. System change Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 to notify Director of Nursing for residents who may require special adaptive equipment. All residents with upper-extremity mobility deficits will be evaluated by 10/23/2020 for appropriate call light usage. Monitor deficient practice Residents identified in call light usage evaluation will be re-evaluated during their quarterly MDS assessment period and as needed. Audits will also be conducted once per week for three months of those identified residents to ensure ability to use call light. Residents needing special adaptive call lights will be reviewed at the next two QAPI committee meetings. Completion date October 23rd, 2020 and ongoing.	

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	245338	A. BUILDING _____ B. WING _____	C 09/18/2020

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F 558	Continued From page 3 lift the cup; she tells us when she wants a drink by calling out." During an interview and observation on 9/17/20, at 10:18 a.m. NA-G went into R17's room to ask if R17 was able to press the call light. NA-G stated the gray bulb was not easy to activate, stating it had to be squeezed in order to turn the call light on. NA-G asked R17 to squeeze the bulb but R17 was not physically able to so. NA-G said R17 "just calls out for help if she needs it." During an interview and observation on 9/17/20, at 2:05 p.m. in R17's room, the administrator pressed the gray call light bulb to make sure it worked and it did. The administrator asked R17 if she could press it. R17 tried, but was not able to. The administrator asked R17 how she gets the attention of the staff and R17 said "I just holler through the door." "If I need something, what else can I do?" Administrator stated it was not acceptable for R17 to have to yell for help; that another type of adaptive call light should be considered in order to allow R17 to obtain assistance without yelling.	F 558		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		10/23/20

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F 604	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and assess a Rock "N Go chair as a potential restraint for 1 of 1 resident (R2) reviewed for restraints. Findings include: R2's annual Minimum Data Set (MDS) assessment dated 6/10/20, indicated R2 was moderately cognitively impaired, required total assistance for transfers and had a history of falls. R2 was admitted on 7/31/18. In addition, R2's Falls Care Area Assessment (CAA) dated 6/10/20, indicated R2 had a history of falls and implemented staff monitoring for risk and evaluate implemented fall precautions. The MDS did not identify restraint use.	F 604	F604 Corrective action for those residents affected On 9/16/2020 Registered Nurse B (RN-B) positioned R2□s Rock N□ Go chair up at a 90-degree angle. RN-B also immediately submitted a request for evaluation from occupational therapy for R2 to be re-evaluated for wheelchair positioning. On 9/16/2020 R2□s care plan was updated to have Rock N□ Go in upright position to enable mobility. Identify other residents	

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F 604	Continued From page 5 R2's care plan revised 9/16/20, during recertification survey, identified fall prevention intervention including; "OT (Occupational Therapy) eval (evaluation) for w/c (wheelchair) positioning, Rock "N Go (specialized wheelchair that seat tilts to an angle of 30 degrees and rocks) for positioning and comfort, place resident at nurse's desk d/t (due to) risk of fall. Prior to this date, the care plan did not identify implementation of R2's Rock "N Go chair. Physician orders dated 1/29/20, indicated orders for "occupational therapy to see and treat related to help in feeding." Physician orders did not address Rock "N Go chair. R2's screening to rehabilitation services dated 1/29/20, indicated "patient had been requiring assistance with eating at meals per nursing" to initiate an assistive device. R2's occupational therapy (OT) treatment note dated 2/10/20, included documentation related to how R2 was seated during meals. Documentation lacked detail of R2 being reassessed for appropriate use of the Rock "N' Go chair. R2's OT Therapist Progress Discharge Summary dated 2/11/20, indicated R2's OT goals were met for positioning and indicated: "The patient exhibits upright posture in rock and go with seat in upright position and while sitting in rock and go and positioning client on opposite side of table to decrease distractions." Locking the breaks of R2's chair was not mentioned. OT plan of care summary indicated Rock 'N' Go chair was signed into implementation on 2/4/20.	F 604	All residents in Rock N□ Go chairs have the potential to be impacted by alleged deficient practices. System change On 9/17/2020 all residents in Rock N□ Go chairs had occupational therapy referrals written to evaluate wheelchair positioning. Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 on proper wheelchair positioning and resident□s rights to be free from restraints. Monitor deficient practice All residents in Rock “N’ Go chairs will be evaluated quarterly during their MDS assessment period and as needed for proper wheelchair positioning. Wheelchair positioning audits will continue once per week for three months and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing.	

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F 604	Continued From page 6	F 604		

R2's Fall Risk Assessment completed on 9/2/20, identified score of 19 (15 or more indicates a high fall risk). Interventions included "staff will continue to observe for effectiveness of fall precautions and risk of falls."

Initial observation on 9/14/20, at 2:43 p.m. R2's breaks on her Rock "N Go chair were locked in place and feet were dangling from the front of the chair, and resident unable to reach the floor. R2 was observed to be attempting to get out of the chair. R2 attempted at least 2 times to push up with both her arms behind her from the Rock "N Go chair to stand up. R2 was able to lift the entire weight of her body up above the seat of her chair, minimum of 2 inches; then sat herself back down into the chair. While attempting to get up, R2 would adjust her pant legs and then pull up her blue non-slip socks. R2 remained seated in the hallway in front of the nurse's station.

During observation on 9/15/20, at 9:00 a.m. surveyor confirmed R2's Rock "N Go chair was locked in place in front of the nurses station. R2's legs observed dangling from the chair, R2 was unable to reach her feet to the floor.

On 9/15/20, at 9:34 a.m. R2 remained in the same location with her Rock "N Go Chair locked and seat tilted upward leaving R2's feet and legs dangling off the chair; R2 remained unable to reach her feet down to the floor.

On 9/15/20, at 2:43 p.m. R2 observed in her Rock "N' Go wheelchair and surveyor confirmed again the chair was locked in place. Again, R2's chair was parked in front of the nurse's station with the health unit coordinator (HUC) providing

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F 604	Continued From page 7	F 604		

limited supervision. R2's legs and feet remained dangling from the Rock "N' Go chair and R2 unable to reach the floor.

R2 was observed on 9/16/20, at 7:14 a.m. again seated in front of the nurse's station with her left foot touching the floor. R2 would then use the foot touching the floor to slightly rock herself in the Rock "N' Go chair, less attempts to place her foot on the floor or pull/tug on her pants or socks. Surveyor observed R2's chair was not tilted up, however confirmed the chair remained locked with the brakes on.

During interview on 9/16/20, at 9:12 a.m. registered nurse (RN)-B questioned in regards to R2's Rock "N' Go chair consistently being placed in a locked position tilted upward. RN-B reported the intervention was to prevent falls and implemented before she started. RN-B confirmed locking and tilting R2's chair was a form of restraint. RN-B followed up by immediately submitting a request for evaluation to occupational therapy for resident to be re-evaluated.

No further documentation was noted related to assessment of R2's Rock 'N Go wheelchair as a potential restraint when chair seat was tilted back and chair breaks were locked.

The facility policy, entitled: Medical Device/Restraint Policy, last revised 9/19, indicated: "Policy: All residents will be assessed for appropriateness and safety before medical devices/restraints are used. Procedure: 4.): Medical Devices and Restraints will be reviewed for appropriateness quarterly with care planning and PRN with resident change of condition.".

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		10/23/20

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F 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to include interventions on the care plan related to edema for 1 of 1 resident (R10) reviewed with significant edema. Findings include: R10's annual Minimum Data Set (MDS) assessment dated 1/27/20, identified R10 had diagnoses including dementia, Alzheimer's disease, type 2 diabetes and edema. R10's MDS indicated R10 had moderate cognitive impairment as shown by her Brief Interview for Mental Status (BIMS) score of 8 out of 15. R10's MDS Care Area Assessment (CAA) did not a trigger care planning concern for skin conditions related to edema. Physician orders dated 7/27/20, recommended staff to encourage R10 "to elevate and to wear her support stockings". R10's care plan last revised on 4/29/20, and Kardex /nursing assistant care sheet dated 7/8/20, lacked direction to nursing assistants (NAs) related to interventions to reduce R10's edema. During observation on 9/14/20, at 3:06 p.m. both of R10's legs from knee to ankle were visibly swollen; R10's left leg was notably more swollen than the right leg. The skin on both legs were pinkish-red, flaky and dry. Neither leg wraps nor support stockings were observed on R10. R10	F 656	F656 Corrective action for those residents affected On 9/16/2020 R10's care plan was updated with interventions related to edema. Staff were reminded to continue encouraging R10 to elevate legs although she frequently declines and continue to document refusals. If R10 continues to refuse interventions staff will consult provider for other possible interventions to meet the resident's needs. Identify other residents Residents with edema or mobility deficits have the potential to be impacted by alleged deficient practices. System change Resident care plans will continue to be reviewed quarterly during their MDS assessment period to ensure the care plans are comprehensive and include interventions necessary consistent with resident rights. Monitor deficient practice Resident care plans will be reviewed quarterly during MDS assessment period	

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F 656	Continued From page 10 was asked about the swelling and denied having any pain. Surveyor observed R10 undoing the velcro strap from her slipper, revealing indentation imprint left from the velcro on the top of R10's foot. On 9/15/20, at 9:07 a.m. R10 was observed with legs not wrapped or in support stockings. R10 continued to wear only velcro slippers. During observation and interview on 9/15/20, at 3:40 p.m. R10 was returning to her room after going outside. R10's legs were observed not wrapped or in support stockings. When asked R10 if elevated her legs, she confirmed nursing assistants have encouraged her to lay down in bed and elevate her legs and she refuses. When interviewed on 9/16/20, at 8:04 a.m. nursing assistant (NA)-D reported she had offered support stockings to R10 to wear, but R10 refused and this was a regular occurrence. NA-D stated she would then inform the nurse that R10 had refused for tracking. NA-D also confirmed she had not encouraged R10 to elevate her legs due to R10 repeatedly refusing. When interviewed on 9/16/20, at 11:07 a.m. NA-C stated "I encourage her to elevate on the bed when she comes back from the dining room after meals." NA-C stated R10 had complied in the past but continues to repeatedly refuse elevating her legs and wearing support stockings. When interviewed on 9/16/20, at 11:20 a.m. nurse manager (RN-X) confirmed R10's comprehensive care plan was not updated with the intervention of daily staff encouragement for R10 to elevate legs and wear support stockings. RN-X was unable to	F 656	to ensure they are comprehensive and include interventions necessary consistent with resident rights and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing.	

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F 656	Continued From page 11 locate documentation in electronic medical record (EMR) and further confirmed the interventions should have been listed under skin conditions on R10's care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice were followed during medication set-up and administration of insulin with a Lantus Solostar pen (long-acting insulin, used to improve blood sugar control in people with diabetes mellitus) for 1 of 1 resident (R33) who received insulin without the pen having been primed according to manufacture's recommendations. Findings include: During observation of medication pass on 9/16/20 at 8:36 a.m. registered nurse (RN)-A prepared R33's medication which included his 8:00 a.m. Lantus insulin. RN-A retrieved the Lantus Solostar insulin pen from the medication cart, removed the tip, pushed on the plunger, and identified this was the method she utilized to remove any air from the insulin cartridge. RN-A opened and attached a needle to the end of the pen, dialed the dose to the ordered 16 units and picked up the items to administer the insulin to	F 658	F658 Corrective action for those residents affected R33 had no adverse outcome from receiving insulin from the pen that was not primed according to the manufacture□s recommendations. RN-A was educated immediately by the DON on how to properly prime insulin pens. Identify other residents There are no other residents in the facility that utilize an insulin pen. System change R33 will be switching to vial insulin, which will result in zero residents in the facility utilizing insulin pens. Licensed nursing staff will be educated on 10/21/2020, 10/22/2020, and 10/23/2020 on how to	10/23/20

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F 658	Continued From page 12 R33. Observation of the Lantus Solostar insulin pen identified there was no date of when it had been opened and RN-A identified according to facility policy the pen should have been dated when it was removed from the refrigerator and opened. When questioned about the facility policy for dating insulin RN-A identified she was going to discard the undated pen and obtain a new unopened pen from the refrigerator. RN-A opened, dated and initialed the new pen and followed the same process of removing the cap from the pen, pushing on the plunger, and applying a new needle. RN-A dialed the pen to the ordered 16 units, but did not prime the pen and waste 2 units according to the manufacture recommendation. RN-A identified R33 was the only resident on the unit utilizing an insulin pen, that other residents had multidose insulin vials. During interview and review of the Lantus Solostar package insert on 9/16/20, at 8:40 a.m. RN-A confirmed she did not waste 2 units of insulin prior to administration of the ordered dose and identified she had not read the manufacture's recommendation, nor was she aware of the need to waste 2 units of insulin to remove air from the needle and insure the accurate dose of insulin was administered. During interview on 9/16/20, at 8:41 a.m. the director of nursing (DON) identified the SoloStar Lantus insulin pen for R33 had not been dated and initialed as to when it had been opened. The DON identified the facility policy had not been followed, and she would have expected the pen to be primed according to manufacture's recommendations prior to administration of the dose of insulin. Review of the Solostar Lantus insulin	F 658	prime insulin pens according to the manufacture□s recommendations. Monitor deficient practice The Director of Nursing will complete an audit once per week for three months to ensure insulin pens are primed according to the manufacture's recommendations and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing.	

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F 658	Continued From page 13 manufacture's package insert identified the need to perform a safety test prior to each injection to insure the pen and needle were working properly and to remove air bubbles from the needle. The process directed: Attach a new needle, Select a dose of 2 units on the dosage selector, hold the pen with the needle pointing upward, tap the insulin reservoir to move any air bubbles to the top of the reservoir, press the injection button all the way in, and check to see if insulin comes out of the needle tip. Repeat if no insulin comes from the needle, then dial the selector to the ordered insulin dose and administer as ordered.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure proper wheelchair positioning for 1 of 3 residents (R16) reviewed for positioning needs. Findings include: R16's electronic medical record identified admission to hospice services on 9/18/18 with diagnosis which included: Parkinson's disease, dementia, anxiety disorder, osteoporosis, and	F 684	F684 Corrective action for those residents affected On 9/17/2020 a referral to occupational therapy was completed for R13 to access proper wheelchair positioning. Staff continue to place pillow under R13□s feet but she frequently pushes it off.	10/23/20

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F 684	Continued From page 14 osteoarthritis. R16's Significant Change Minimum Data Set (MDS) assessment dated 7/21/20, identified severe cognitive impairment and total dependence for bed mobility, transferring, locomotion on/off unit, toileting, eating and personal hygiene and extensive assistance required for dressing. R16's hospice care plan dated 9/19/19, included: altered behavior related to cognitive impairment. Resistive and refuses care. Intervention included; insure safety and re-approach later. No therapy evaluation or plan was documented as completed for seating or positioning. Observations included: On 9/15/20, at 2:00 p.m. R16 was seated in Rock 'N Go chair (specialized wheelchair that seat tilts to an angle of 30 degrees and rocks) with feet dangling with no support, the back of the chair was against the bed, with the bed against wall. R16's upper body was leaning towards the left side of the chair and she had her eyes closed and arms curled onto her chest. 2:30 p.m. Position remained unchanged. 3:30 p.m. No change in positron, eyes closed and resting quietly. 4:36 p.m. No change in position. 5:30 p.m. R16 was observed being transported by staff to the dining room in her Rock "N Go chair with her feet dangling unsupported. On 9/16/20, at 7:31 a.m. R16 was seated in her Rock 'N Go chair, the chair back was against the bed, and the bed was against the wall. R16's feet dangling above the floor with no support.	F 684	Identify other residents All residents in Rock N□ Go chairs have the potential to be impacted by alleged deficient practices. System change On 9/17/2020 all residents in Rock N□ Go chairs had occupational therapy referrals written to evaluate wheelchair positioning. Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 on proper wheelchair positioning and resident□s rights to receive quality care. Monitor deficient practice All residents in Rock N□ Go chairs will be evaluated quarterly during their MDS assessment period and as needed for proper wheelchair positioning. Wheelchair positioning audits will continue for three months and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing.	

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8:00 a.m. R16 was transported to the dining room for breakfast in her chair and her feet dangled with no support.
8:45 a.m. R16 was returned to her room, remained seated in the Rock N Go chair with her feet dangling above the floor. The TV was on and the chair had been positioned in front of the TV. R16 sat with her eyes closed and did not indicate interest in the game show on TV nor did she respond to attempts at conversation.
9:37 a.m. R16 remained in the same position with her feet dangling above the floor.
10:00 a.m. nursing assistant (NA)-A entered the room and positioned a pillow on the floor beneath R16's feet. NA-A identified R16 did not have foot rests due to kicking her legs and banging her feet and legs against the foot rests.

During interview on 9/15/20, at 4:42 p.m. NA-A identified R16 was set up and assisted with meals as she would allow and the amount of assistance varied from limited to total assistance depending on the day and her state of mind. NA-A identified R16 was usually up in her Rock "N Go chair from when she got up in the morning until after the noon meal, when she was transferred into bed to rest, until about 3:00 p.m. when she was assisted back to her chair. NA-A confirmed R16 had been in her chair since she arrived at 2:00 p.m. and would be repositioned every 2-3 hours and transferred into bed at 7:00 p.m. for the night. She was not aware if R16 had been transferred into bed prior to her arrival, since she was seated in her chair when she arrived for her shift.

During interview on 9/16/20, at 10:57 a.m. with RN-A identified R16 was on hospice services and the Rock "N Go chair had been provided for R16's comfort and positioning. RN-A identified

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she was not certain why R16 didn't have leg rests or support for her feet.

During interview on 9/16/20, at 10:59 a.m. NA-B identified R16 required total assistance with all personal care. NA-B identified R16 is able to move her chair by rocking and frequently moves herself back against her bed. NA-B identified R16 is transferred into her chair when assisted up for the day and bolsters positioned to help maintain upright positioning. NA-B identified R13 can have a pillow beneath her feet when she allows it but she usually pushes it away. When asked about the lack of foot pedals on the chair, NA-B identified the pedals were not on the chair because of a safety risk because R16 kicked her feet and banged against the pedals. R16's care plan was observed posted on the back of the door in the bathroom and NA-B identified she was aware of the care plan in the bathroom, but the document did not contain any interventions for supporting R16's feet and lower legs.
.
During observation and interview on 9/17/20 at 8:57 a.m. with Occupational Therapist (OTR) identified there was concern related to R16's feet dangling above the floor. The OTR identified she would need additional information to perform a full assessment, but a resident seated in a chair should have some form of support for their feet while seated in a chair. The OTR identified an issue with tone in resident's legs, as identified would be a matter of positioning correctly to allow for support.

R16's Rehabilitation screening documentation dated 5/2/19, identified it had not been completed due to R16 receiving Hospice services. Interview with the rehab therapy manger provider on

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F 684	Continued From page 17 9/16/20 at 1:21 p.m. identified R16 had not received therapy services since 2014 and an identified a concern with seating would indicate the need for an evaluation. Rehab therapy manager stated it was the facility's responsibility to request an evaluation to be completed.	F 684		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop behavioral interventions for a resident with hallucinations and delusions for 1 of 1 resident (R17) reviewed for behavioral health services. Findings include: R17's facesheet printed 9/15/20, identified diagnoses including major depression, anxiety disorder and insomnia. R17's quarterly Minimum Data Set (MDS) assessment dated 7/21/20, indicated R17 was cognitively intact, had moderate difficulty hearing,	F 740	F740 Corrective action for those residents affected On 9/17/2020 RN-A completed the Clinician Regulatory Visit Worksheet in advance to R17□s provider visit on 9/21/2020. RN-A noted R17 has had an increase in episodes of hallucinations/delusional thinking and that R17 had a Urinalysis completed on 9/8/2020 and was negative for a UTI. On 10/1/2020 provider started R17 on Vitamin B12 to help decrease mental confusion due to deficiency.	10/23/20

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F 740	Continued From page 18 moderately impaired vision, clear speech, was understood and could usually understand. R17 was totally dependent on staff for bed mobility, transfers, eating, toileting and personal hygiene. The MDS further indicated no evidence of acute change in mental status from baseline and that R17 had no hallucinations and delusions. R17's care plan printed 9/15/20, indicated R17 had altered mood related to depressive disorder, anxiety and trouble sleeping. Interventions included assess for changes in mood and review at weekly interdisciplinary team meetings and contact physician to report changes as needed. The care plan did not include interventions for R17's hallucinations and delusions. In November 2019 and January 2020, R17's Cymbalta (a medication used for depression, anxiety and pain) dosage was modified due to R17 experiencing hallucinations. An interdisciplinary team meeting progress note dated 5/5/20, indicated R17 was on Cymbalta for anxiety and it was noted to be effective. The progress note further indicated the facility would continue to monitor effectiveness of the medication each day, and report any changes. During record review it was noted that nurse practitioner (NP)-G had an audio/video visit with R17 dated 7/23/20, and documented R17 had occasional episodes of slightly altered thought process and or behaviors. R17's progress notes indicated, in August 2020, there were seven progress notes related to hallucinations and/or delusions. During the first nine days of September 2020, there were eight progress notes. Notes included entries such as:	F 740	Identify other residents All residents have the potential to be impacted by alleged deficient practices. System change Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 to inform the Director of Nursing of residents who develop hallucinations or delusions. When the DON is notified of a resident that has developed hallucinations or delusions behavior logs will be implemented to monitor changes. Recent medication changes and any other acute changes that may be contributing to the change in mental status will also be reviewed and interventions will be put in place to protect the resident. Facility will also notify provider of the change in mental status to. Monitor deficient practice Residents with behavioral health concerns will be reviewed quarterly during their MDS assessment period to ensure the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care are attained or maintained. These identified residents will be reviewed at the next two QAPI Committee meetings. Completion date	

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F 740	Continued From page 19 "My room is full of snakes and I need to go to maintenance to sweep them out." "Seeing her sons as little boys and reprimanding them." "Talking to people in her room, looking at the ceiling, upset with them as they were in the way and spilling popcorn." "Having delusions and hallucinations various times this shift." "Hallucinating most of the day." During an interview on 9/15/20, at 2:38 p.m. registered nurse (RN)-A stated R17 had been delusional with hallucinations this past month, stating we thought she had a urinary tract infection (UTI), but the urinalysis (UA) was negative for infection. RN-A stated R17 had not had a psychiatric evaluation and stated "she could use one; we need to get a diagnosis." When asked how resident changes were reported to a provider, RN-A stated there was a paper log on a clipboard where staff could write questions and concerns for providers when they came to the facility to see residents. RN-A looked at the log and pointed out one entry dated 9/3/20, which indicated: R17 hasn't been herself due to mood/behavior. UA to rule out UTI? RN-A noticed a provider was scheduled to see R17 on 9/21/20, but was "not sure how to makes him aware of R17's hallucinations." RN-A discussed this with nursing assistant (NA)-F and they decided they would tell the health unit coordinator (HUC)-A. During an interview on 9/16/20, at 8:36 a.m. HUC-A and director of nursing (DON) were asked to describe the process a nurse would use to notify a provider of changes in a resident's condition. Both described the use of a clip board used to communicate concerns to be addressed at the next provider visit. In addition, HUC-A described a paper rounding form that was filled	F 740	October 23rd, 2020 and ongoing.	

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F 740	Continued From page 20	F 740		

out prior to provider visits with detailed information identifying specific concerns. HUC-A stated a rounding form had not been initiated for R17.

During an interview on 9/16/20, at 12:26 p.m., the DON was aware of R17's hallucinations and delusions, stating it had been going on for three weeks. The DON stated a UA had been done on 9/8/20 to determine if R17 had a UTI which could cause hallucinations, but she did not know the results.

During an interview on 9/16/20, at 12:34 p.m. social worker (SW)-A stated she was aware of R17's hallucinations and delusions; "when I hear that, I think UTI and to push fluids."

During an interview on 9/16/20, at 12:55 p.m., the DON provided documentation that the nurse practitioner (NP) was aware of R17's hallucinations. A progress note dated 9/11/20, at 11:23 a.m. indicated: fax received from nurse practitioner (NP)-G: UA along with culture and sensitively were reviewed. R17 does not appear to have a UTI at this time. No treatment is indicated at this point. DON was asked what would happen next to address R17's delusions and hallucinations and she stated pharmacy would look at it.

During an interview on 9/17/20, at 9:54 a.m., the administrator stated R17's hallucinations started three weeks ago and stated R17 should have had a visit with a provider, adding she hoped R17 would be on the NP list right away, as a pharmacy review would not be the appropriate first step.

During an interview and observation on 9/17/20,

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at 10:53 a.m., (RN)-A was filling out a document titled Clinician Regulatory Visit Worksheet in advance of R17's provider visit on 9/21/20. Her notations included: R17 has had an increase in episodes of hallucinations/delusional thinking. Urinalysis results from 9/8/20 were negative for UTI.

During a telephone interview on 9/17/20, at 2:58 p.m. consultant pharmacist (CP)-H stated stated he did not suggest something for R17's hallucinations and delusions during pharmacy reviews because they were not distressing to R17; they were not disruptive to her; she's eating; there was no potential for harm.

On 9/17/20, at 3:15 p.m. DON provided a copy of a paper log indicating communication with a provider regarding R17. Log entry dated 8/19/20 indicated: Change in mental status, hallucinating/delusions thinking, yelling. Provider ordered melatonin (sleep aid medication) at bedtime for insomnia.

During an interview on 9/18/20, at 9:28 a.m. with the administrator and DON, the DON stated R17 does not always have behaviors, stating sometimes R17 is very thankful and happy and in a good mood. In the snap of a second, she can get angry and yell at a picture on the wall, or talk to people who aren't in the room. The administrator acknowledged there was a lot of documentation regarding R17's hallucinations and delusions and stated she hoped it had been reported to the provider. The administrator was unaware R17 had no diagnosis related to hallucinations and delusions, despite these behaviors being documented; "not sure why they aren't talking about this." The administrator stated

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F 740	Continued From page 22 the first time an acute change was noticed, the provider should have been notified until R17's hallucinations and delusions were addressed." The administrator reviewed notes about a recent urinalysis where staff thought she might have a UTI explaining the hallucinations, but the test was negative. The administrator stated "my expectation is that staff would have followed up when the culture came back negative to see what else is going on." Facility policy titled: Physician and Family Notification, with revised dated of 9/19 indicated the following: 1. Purpose: to keep physician up to date on changes in residents condition. 2. Policy: a residents physician will be kept informed about the residents condition. 3. Procedure: Notify physician as soon as possible for: a. Unmanageable behavior. 4. Communication: a. Do a thorough assessment of the resident. b. Communicate between shifts any changes so proper notification can be made. c. Document time of call, name of provider, what was reported and any comments or new orders. d. Update the residents plan of care with new or additional problem, goal and approaches if applicable.	F 740		
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 -	F 812		10/23/20

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F 812	Continued From page 23 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure once food served has left the kitchen does not return to the kitchen, proper food storage and labeling of refrigerated and dry food, removal of expired food, proper storage/cleanliness of dishes, cleanliness of mixers, and disinfection of thermometer after temping food. This had the potential to affect all 37 residents residing in the facility. Findings include: During an interview and observation on 9/14/20, at 1:45 p.m. surveyor and dietary manager (DM)-A did an initial walk thru of the kitchen. During walk thru, there was a white towel observed on the floor with red and brown coloration on it. The towel was under the bottom shelf of the walk-in cooler where meat was thawing in a pan. DM-A stated she was unsure	F 812	F812 1) Corrective action for those residents affected R31 had no adverse outcome from consuming the food that was on her plate that was taken back into the kitchen by the Dietary Aid (DA-A) to get a hamburger patty. DA-A was immediately educated by the Certified Dietary Manager (CDM) regarding taking plates back into the kitchen for more food after they have left the kitchen. Identify other residents All residents have the potential to be impacted by alleged deficient practices. System change	

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F 812	Continued From page 24 what that was from and figured over the weekend something happened and the staff did not get it cleaned up fully. Also observed inside walk-in cooler, were expired products including: lactose milk dated 9/2/20, skim milk dated 9/1/20, and small cartons of lactaid in a box with one on top of box dated 4/21/20. DM-A stated she was unsure if the milk had been served. There was a cart with silverware in containers next to large mixer where the silverware were clean in the containers but the cart itself had crumbs on each shelf. DM-A confirmed the mixers were soiled and stated they rarely use either of the mixers and was not sure last time they were used. During the walk through of the pot and pan area, there were multiple stacked pans that had moisture in-between the pans when pulled apart and one pan with dry egg on bottom of the pan. Also in area was an open package of bacon bits with no date when opened. DM-A stated she would expect them to be dated. DM-A removed from area and surveyor was unable to see the manufacturer expiration date. During the walk thru downstairs in the dry storage area, expired products were found including: one thickened orange juice dated 8/16/20; three thickened kiwi strawberry juices with expiration dates of 6/7/20, 7/18/20, and 8/27/20; one thickened apple juice dated 6/19/20; and two large garlic parmesan sauce containers with expiration date of 6/12/20. DM-A stated the products were to be checked for expiration dates when stocking incoming products, as they are to rotate the new product to the back. During an observation on 9/14/20, at 5:13 p.m. Cook-A used a white rag to wipe thermometer in between checking food temperatures without disinfecting. Foods checked included onion rings, green beans, soup, and corn dogs.	F 812	Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 regarding food not being able to be taken back into the kitchen for more food after the plate has left. Monitor deficient practice The CDM will complete audits once per week for three months to ensure staff start with a fresh plate if a resident request different or more food from the kitchen rather than taking their plate back into the kitchen and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing. 2) Corrective action for those residents affected No residents were affected by the alleged deficient practices. Identify other residents All residents have the potential to be impacted by alleged deficient practices. All expired and unlabeled food was immediately thrown away. System change The morning cook will throw away all expired and unlabeled food in the main kitchen twice per week during the food	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 During an interview on 09/14/20, at 7:00 p.m. Cook-A confirmed restocking dry food items and checking expiration of items daily. Cook-A further confirmed doing various jobs in the kitchen such as dishwashing, and verified pots and pans were air-dried on drying rack prior to being stacked together and put away During a follow up walk through of the kitchen on 9/16/20, at 7:41 a.m. both mixers remained soiled with food debris. Cook-B confirmed the mixers were soiled and stated they did not use the mixers often. During a follow up walk through and interview on 9/16/20, at 10:36 a.m. with DM-A, moisture was found in one large pan, sandwiches in cooler were not dated, spill on floor of cooler was cleaned up, and expired lactaid cartons remained in the cooler. DM-A confirmed the sandwiches were from yesterday and should have been dated. DM-A asked staff member to remove the expired lactaid cartons. DM-A confirmed the expired items observed in the downstairs dry storage area on 9/14/20, had not been disposed of yet and remained where originally identified. During an interview on 9/16/20, at 10:43 a.m. cook-B confirmed when temping food the thermometer should be cleansed with an alcohol wipe after each use. During an interview on 9/16/20, at 12:58 p.m. DM-A confirmed dietary staff were responsible for cleaning equipment and areas after use. DM-A stated the cook is responsible for checks on outdated food in refrigerators and freezers weekly but was not documented when completed. DM-A	F 812	delivery and as needed. Nursing staff will throw all expired and unlabeled food weekly in the kitchenettes and as needed. Education will be provided to staff 10/21/2020, 10/22/2020, and 10/23/2020 regarding expired food and labeling food. Monitor deficient practice The CDM will complete audits once per week for three months to ensure there is no expired food in fridges and all food is labeled and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing. 3) Corrective action for those residents affected No residents were affected by the alleged deficient practices. Identify other residents All residents have the potential to be impacted by alleged deficient practices. All pans containing moisture or food were immediately pulled and cleaned. All unused mixers were taken out of the kitchen and remaining blender was cleaned. System change Pans will only be single placed on the racks. Remaining blender will be cleaned	

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	245338	A. BUILDING _____ B. WING _____	C 09/18/2020

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F 812	Continued From page 26 confirmed the PM cook was responsible for checking dry good outdates when restocking items. During observation and interview on 9/17/20, at 11:33 a.m. registered nurse (RN)-B confirmed the following observations of the south unit refrigerator: 5 expired lunchables in lower drawer with expiration dates from March 2020 and July 2020 and orange cuties were moldy. RN-B removed the items. RN-B confirmed dietary staff stocked the refrigerator. RN-B stated the aides were to document the temperatures morning and evening and all staff should be checking for expiration dates. The north kitchenette had expired chocolate milk dated 9/15/20, potato salad in container not covered or dated and homemade salsa not labeled or dated. RN-B stated the salsa likely belonged to a staff member and confirmed the refrigerator was to be for resident use only as the sign on the refrigerator stated. The sheltering arms area refrigerator had two large butter blocks with no date, parmesan cheese dated 12/17/19, and chocolate milk dated 9/10/20. During an interview on 9/17/20, at 12:23 p.m. Cook-B confirmed the evening staff stock the unit refrigerators twice weekly and as needed and were supposed to check for outdates. During a follow up interview on 9/17/20, at 1:12 p.m., DM-A confirmed dietary staff delivered items to unit refrigerators and the nursing staff put them away and would think the nursing staff would check outdates. DM-A confirmed there should be a month and date on the butter blocks. DM-A stated the kitchen does not provide lunchables so must be from a family member for	F 812	after each use and as needed. Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 to check pans for cleanliness and dryness prior to putting away and how to clean the blender. Monitor deficient practice The CDM will complete audits once per week for three months to ensure pans and the blender are clean and dry and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing. 4) Corrective action for those residents affected No residents were affected by the alleged deficient practices. Identify other residents All residents have the potential to be impacted by alleged deficient practices. Cook-B was immediately educated on cleansing the thermometer with an alcohol wipe after each use. System change Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 on the single use of alcohol prep pad.	

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F 812	Continued From page 27 a resident and the aides dealt with food brought in by family. DM-A stated nursing staff should know to label and date food brought in by family. DM-A further stated she expected dietary staff to label and date food. During an interview on 9/17/20, at 1:27 p.m. NA-B confirmed staff on units label and date foods if brought in by family, monitor for outdates and discard items as necessary. NA-B confirmed unit staff monitored the temperatures of refrigerator and freezer and were to notify maintenance with out of range temperatures. During observation of the evening meal on 9/14/20 at 5:38 p.m., R31 was seated at the table with a plate containing slices of turkey and mashed potatoes. R31 looked at her plate and motioned dietary aide (DA)-A to come over to her. DA-A spoke with R31, picked up her plate with a gloved hand and carried it into the main serving area of the kitchen. She returned with the same plate containing the mashed potatoes and set the plate on the table in front of R31. R31 again spoke with DA-A, who picked up the plate and again walked into the main serving area of the kitchen. She returned with R31's plate containing a hamburger patty and the mashed potatoes which she again placed on the table in front of R31. During interview on 9/14/20 at 5:45 p.m. DA-A identified R31 did not want turkey so she picked up the plate from the table in front of R31, carried the plate into the main kitchen serving area, removed the turkey from plate and returned the same plate containing the mashed potatoes and placed it on the table in front of R31. R31 looked at the plate and requested DA-A to bring her a	F 812	Monitor deficient practice The CDM will complete audits once per week for three months to ensure staff are using alcohol prep pads to clean thermometers between each use and brought to QAPI Committee meetings for review. Completion date October 23rd, 2020 and ongoing.	

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F 812	Continued From page 28	F 812		

burger patty, so DA-A, verified she had again picked up R31's plate carried it back into the kitchen serving area, retrieved a burger patty from the steam table, placed it onto the same plate with the potatoes and returned it to R31 who began to eat. DA-A identified she had received education on infection control, but had not thought about taking R31's plate back and forth from the table to the kitchen serving area as an infection control problem.

During interview with the certified dietary manager (CDM) on 9/14/20, at 5:49 p.m. it was verified food that had been served was not to be taken back into the kitchen serving area, but should have been taken to the dishwashing area, and a new plate, with food obtained from the steam table plated and served to R31. The CDM identified education had been provided on infection control measures, and DA-A should have known that once food was taken from the kitchen serving area it could not be taken back into that area of the kitchen and a new plate of food should have been served.

Facility policy titled; Dry Storage Areas Policy and Procedure, dated 4/20, indicated the floors, walls, shelves and other storage areas are kept clean; leaking foods should be disposed of promptly to prevent contamination of other foods; new stock is placed in back of previously delivered items so that older stock will be issued first; refrigerated and frozen foods are dated upon delivery, foods with expiration dates are used prior to the date on the package.

Facility policy titled; Meat and Vegetable Preparation Policy and Procedure, dated 2013, indicated meat is defrosted using safe thawing

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F 812	Continued From page 29	F 812		

methods in the refrigerator in a drip proof container and in a manner that prevents cross contamination.

Facility policy titled; General Food Preparation and Handling Policy and Procedure, dated 2013, indicated the kitchen and equipment are clean and sanitized as appropriate; and food is covered for storage.

Facility policy titled; Food Safety and Sanitation Policy and Procedure, dated 2013, indicated foods are refrigerated and stored at or below 41 degrees Fahrenheit; foods are frozen and stored at a temperature that keeps them frozen solid; leftovers are labeled, covered, and dated when stored and used within 72 hours; and foods with expiration dates are used prior to the use by date on the package.

Facility policy titled; Cleaning Dishes/Dish Machine Policy and Procedure, dated 2013, indicated during the unloading process to visually inspect all items for cleanliness and if not clean to repeat steps; allow the dishes to air dry on dish racks, do not dry with towels; and remove the dishes, inspect for cleanliness and dryness and put them away if clean.

Facility policy titled; Food Storage Policy and Procedure, dated 2013, indicated food is arranged in food groups in the storage areas to make it easier to store, locate, and inventory; supervise the person designated to put stock away to make sure it is rotated properly; leftover food is stored in covered containers or wrapped carefully and securely with each item clearly labeled and dated before being refrigerated; every refrigerator must be equipped with an

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F 812	Continued From page 30 internal thermometer; and each nursing unit refrigerator/freezer will be supplied with thermometer and monitored for appropriate temperatures. Facility policy titled; Food Availability Policy and Procedure, dated 2013 indicated the food service staff will deliver items daily to the appropriate kitchenette or pantry replenishing items according to predetermined levels and are also responsible for: rotating stock and removing outdated items; checking the temperatures of the refrigerators/freezers weekly and maintain documentation; and cleaning and sanitizing refrigerators on a regular cleaning schedule and as needed for spills. A policy and procedure for cleaning thermometer in between food items checks was requested but not provided. A policy on handling of food after taken from the kitchen serving area was requested but not provided, but was identified as part of the infection control practice.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		10/23/20

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F 880	Continued From page 31	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 32 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the CDC's recommendations to prevent the spread of COVID-19 in congregate settings to ensure residents and their visitors utilized and removed personal protective equipment (PPE) in a manner to prevent the spread of infection during window visitations. This had the potential to affect all 38 residents, staff, contract staff, and essential care givers. Findings include: On 9/16/20, at 12:52 p.m. R9 was observed having a window visitation with her two son at the far end of the east hall on the north nurse station. It was noted the window was wide open; R9 and her two sons were less than 6 feet apart. Neither R9 nor either of her sons were wearing any kind of face mask. One son was observed to be leaving forward, close to the window screen, while R9 was seated close to the window in her	F 880	F880 Corrective action for those residents affected Director of Nursing spoke to R9 and her family members that were participating in the window visit to remind them on the guidelines in place for window visits. R9 is independent and called her sons and initiated the window visit on her own, no formal appointment was made through the facility. If a formal appointment was made, the family would have been reminded to wear a mask and remain six feet apart and the resident would have been assisted to put on her mask. Identify other residents All residents have the potential to be impacted by alleged deficient practices.	

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F 880	Continued From page 33 wheelchair, less than 3 feet from the screen. Observed nursing assistants (NA)-X, NA-X and another unnamed NA present and visually observing the window visit. During an interview on 9/16/20, at 12:55 p.m. Director of Nursing (DON) was asked the requirements for a window visit; DON stated the resident and visitors have to be 6 feet apart and wearing masks. Surveyor then brought DON to the waiting room to observe the window visit. DON confirmed by verbalizing R9 and visitors were not 6 feet apart and not wearing masks. DON spoke to family members and resident to remind them of the rules. On 9/16/20, at 1:39 p.m. the DON further reported R9 was independent and called her sons and initiated the window visit on her own; no formal appointment was made through front desk staff. DON stated if a formal appointment was made, the family would have been reminded to wear a mask, and the resident would have been assisted to put on her mask. DON stated she reeducated the three nursing assistants (NA-X, NA-X and the unnamed) observed present and not intervening for proper window visit procedure. Facility policy titled: Policy From: Window Visitation, effective date: 6/12/20, details requirement to schedule the visit with the receptionist or nurse manager in increments of 30 minutes per visit. "If a resident's window will be open during the visit, the resident should stay back 3 feet from the window, and should wear a cloth mask. The family member visiting the resident should sit 3 feet back from the window outside the building. The family member should also be wearing a cloth mask."	F 880	Each resident will be assessed by 10/23/2020 to determine their ability to understand or willingness to comply with social distancing and care plan interventions to promote compliance. System change The QAPI Committee completed a root cause analysis on the incident and identified contributors and solutions to prevent future occurrence. Education will be provided to staff on 10/21/2020, 10/22/2020, and 10/23/2020 on the guidelines of window visits and the importance of both the residents and their family wearing masks and remaining six feet apart. Signs promoting mask wearing are posted in resident areas. Policies and procedures to provide for and enforce social distancing among residents/staff and to provide for social distancing during dining and/or activities have been created. Monitor deficient practice The Director of Nursing, the Infection Preventionist and other facility leadership with conduct rounds throughout the facility on each shift to ensure social distancing is being maintained by all staff and residents during various times of day and various activities. The rounds will be conducted every day for four weeks, or until 100% compliance is obtained. Then the audits/monitoring may be decreased in frequency. Audits will be brought to QAPI Committee and Pandemic Committee	

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F 880	Continued From page 34 CMS' recommended infection prevention and control (IPC) practices in the Center for Clinical Standards and Quality/Survey & Certification Group (QSO-20-39-NH), subject titled: Nursing Home Visitation-COVID-19, dated 9/17/20, indicated: "When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time." "Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission: Face covering or mask (covering mouth and nose) and social distancing at least six feet between persons."	F 880	meetings for review. Completion date October 23rd, 2020 and ongoing.	

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

PRINTED: 10/23/2020
FORM APPROVED
OMB NO. 0938-0391

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	245338	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/16/2020**

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K 000	INITIAL COMMENTS 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 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. 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. Johns Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care 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	K 000		

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

Electronically Signed | 10/15/2020

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	K 000		

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.

St. Johns Lutheran Home building was constructed at 4 different times. The original building is a 3 story building and was constructed in 1960. It was determined to be of Type II(222) construction. In 1964, a 2 story addition was added to the northeast and southeast wings that was determined to be of Type II(222) construction. In 1967, a 2 story addition was constructed to the North and South that was determined to be of Type II(222) construction. In 1980, a 2 story addition was added to the South Annex and was determined to be Type II (111).

The facility is fully sprinkled . The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 79 beds and had a census of 37 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper means of visable means of egress or signage in accordance with the Life Safety Code NFPA 101 - 2012 edition (7.8, 19.2.8, 7.12.1(1b), 7.2.2.5.5.11) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observations and staff interview revealed the following: During walk-through of the facility observed there was no emergency lighting in the boiler room to illuminate the means of egress This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 281	K281 Albert Lea Electric will be installing four emergency lights in the boiler room by 10/17/2020 to provide emergency lighting in the boiler room to illuminate the means of egress. Aric Bauman, Maintenance Director	10/17/20
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101	K 291		10/13/20

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K 291	Continued From page 3 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test emergency lighting in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.2.9.1) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 1:00 PM on 09/16/2020, observations and staff interview revealed the following: During documentation review, records provided revealed that the facility had not completed emergency lighting monthly testing (Nov 2019 thru June 2020), and no record of 90 min annual testing This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	K291 A 90 minute emergency lighting test was completed on 10/13/2020 by facility maintenance staff. Monthly and annual 90 minute emergency lighting testing have been added as reoccurring tasks in the TELS system to ensure completion and documentation. 10/13/2020 Aric Bauman, Maintenance Director	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		9/18/20

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K 293	Continued From page 4 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper operation of exit signage in accordance with the Life Safety Code NFPA 101 - 2012 edition (7.10, 19.2.10.1) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observations and staff interview revealed the following: During walk-through of the facility observed that the (2) emergency exit signs located at cross-over area between SNF and Assisted Living were not illuminated This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 293	K293 The 2 emergency exit signs located at cross-over area between the skilled nursing and the assisted living have been replaced by facility maintenance staff. The tasks of checking illumination of exit signs has been added to the monthly tasks in the TELS system to ensure completion and documentation. 9/18/2020 Aric Bauman, Maintenance Director	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		9/26/20

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K 324	Continued From page 5 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain proper inspection / cleaning of range hood assembly in accordance with the Life Safety Code NFPA 101 - 2012 edition (NFPA 96 - 11.7) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observation and documentation reviewed revealed the following: During documentation review, no records were provided to confirm the cooking facility exhaust hood was being inspected and cleaned on an annual basis. Maintenance Director shared that last known cleaning of hood was completed 2011 This deficient practice was confirmed by the	K 324	K324 The exhaust hood in the cooking facility was cleaned by Fairmont Hood and Duct. The annual hood cleaning has been added the annual tasks on the TELS system to ensure completion and documentation. 9/26/2020 Aric Bauman, Maintenance Director	

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K 324	Continued From page 6 Facility Maintenance Director at the time of discovery.	K 324		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain proper records in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.5.12, NFPA 10) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observation and documentation reviewed revealed the following: During documentation review, no records were provided to confirm monthly fire extinguisher inspections This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	K355 All fire extinguishers were checked by facility maintenance staff. The tasks of checking and initialing fire extinguishers has been added to the monthly tasks on the TELS system to ensure completion and documentation. 9/28/2020 Aric Bauman, Maintenance Director	9/28/20
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		9/29/20

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K 511	Continued From page 7 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 document review and staff interview, the facility failed to secure electrical panels in resident corridors in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observations and staff interview revealed the following: During walk-through of the facility observed unsecured electrical panels in the following resident accessible corridors: 2NF FL - SE Nurses Station; Adjacent to RM226; Adjacent to RM203; Adjacent to RM112 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	K511 All unsecured electrical panels were secured by facility maintenance staff. 9/29/2020 Aric Bauman, Maintenance Director	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		9/30/20

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K 712	Continued From page 8 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 document review and staff interview, the facility failed to conduct fire drills in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.1.7) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observation and documentation reviewed revealed the following: During documentation review, records provided indicated that the facility had not completed fire drills for: Q1 - 1st & 2nd shifts; Q2 - 2nd & 3rd shifts; Q3 - 1st & 3rd shifts; Q4 - 1st shift During documentation review, records provided indicated that the facility did not maintain proper fire drill calendar separation for Q4 - 2nd & 3rd shifts This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 712	K712 The fire drills have been entered in the correct sequence in the TELS system and the proper fire drill calendar was instated. 9/30/2020 Aric Bauman, Maintenance Director	

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K 712	Continued From page 9 discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to test and maintain door assemblies in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (2010 NFPA 80)) This deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observations, staff interview, and documentation reviewed revealed the following: During documentation review, no records were provided to confirm fire door inspections had being completed	K 761	K761 The fire door latch and gap inspection of all fire doors will be completed by facility maintenance staff by 10/17/2020. The task of fire door inspections has been added to the annual tasks on the TELS system to ensure completion and documentation. 10/17/2020 Aric Bauman, Maintenance Director	10/17/20

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K 761	Continued From page 10 During walk-through of the facility observed hardware in the following doors did not operate properly upon testing: 2nd FL - smoke barrier doors adjacent to RM273; 2nd FL Dining Rm smoke barrier door This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 761		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident 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	K 920		9/16/20

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K 920	Continued From page 11 by: Based on observation and staff interview, the facility failed to maintain proper electrical safety in accordance with the Life Safety Code NFPA 101 - 2012 edition (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 deficient practice could affect (37) residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 09/16/2020, observations and staff interview revealed the following: During walk-through of the facility observed appliances connected to a power-strip in the Memory Care Unit - Nurses Station This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	K920 The power-strip in the memory care unit at the nurse□s station was removed on 9/16/2020. Staff were educated that they cannot plug an appliance into a power-strip. Power cord and extension cord inspections were added as a task in the TELS system to reoccur every six months to ensure they are not in use. 9/16/2020 Aric Bauman, Maintenance Director	