Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

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

RE: CCN: 245635
Cycle Start Date: January 10, 2024

Dear Administrator:

On February 2, 2024, we notified you a remedy was imposed. On February 20, 2024, the Minnesota Departments 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 February 8, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 17, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of February 2, 2024, 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 February 17, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 8, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 2, 2024

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

RE: CCN: 245635
Cycle Start Date: January 10, 2024

Dear Administrator:

On January 10, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 location for imposition. The CMS location 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 February 17, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $11,995; 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 February 17, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Johns On Fountain Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2024. 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 10, 2024 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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/8/24-1/10/24 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/8/24-1/10/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56358622C (MN00092600) H56358623C (MN00098632) H56358624C (MN00097360) H56358750C (MN00099810) H56358751C (MN00099814) H56358970C (MN00091427) H56359115C (MN00091574) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

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

Electronically Signed | 02/05/2024

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R19) was notified of lab and x-ray results when requested. Findings include: R19's quarterly Minimum Data Set (MDS)	F 552	F000 Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted	2/5/24

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F 552	Continued From page 2 assessment dated 11/29/23, indicated R19 had no cognitive impairments, no behaviors, independent with eating, oral hygiene, dressing, personal hygiene, and mobility; required partial/moderate assistance with toileting, bathing, utilized a wheelchair, diagnoses included: heart failure, chronic respiratory failure, and sleep apnea. R19's care plan reviewed 12/13/23, indicated alteration in thought process r/t (related to) primary diagnosis of fibromyalgia (disorder that causes pain and tenderness throughout the body), obstructive pulmonary disease (airflow blockage and breathing-related problems), congestive heart failure, chronic bronchitis, good recall ability, indicating no concerns with memory/cognition and interventions included encourage independent decisions, offer information as needed, keep consistent staff and environment as much as possible. R19's progress note dated 12/26/23 at 2:51 p.m., health unit coordinator (HUC)-A indicated R19 complains pain in knuckles right index finger, thumb, right hand knuckles swelling, pain goes down to wrist; physician orders see fax lab ordered, new lab orders connective tissue disease cascade (inflammation that involves the joints, skin), CRP (c-reactive protein test checks for inflammation in the body) and uric acid (high levels can indicate gout which is a type of inflammatory arthritis that causes pain and swelling in your joints), to be drawn next lab day. R19's progress note dated 12/28/23 at 4:30 p.m., HUC-A indicated findings thumb arthritis, there is narrowing of the interphalangeal joint, no fracture displacement, impression: finger arthritis.	F 552	solely because of requirements under state and federal laws. F552 St. John's has and always will ensure its residents are informed of, and participate in, his or her treatment. R19 was visited by the DON on 1/11/2024 to ensure lab and x-ray results were clearly communicated to her. A random sampling of like residents was interviewed by Social Services on or before 1/19/24 to determine if there are any concerns regarding their lab and x-ray results. No concerns were noted. The Informing Residents of Health, Medical Condition and Treatment Options policy and procedure was reviewed on 1/15/2024 with no noted changes. Training and education of the policy and procedure was completed with social services and nursing staff on or before 1/19/2024. Anyone not yet completed will be suspended from the schedule until training and education is completed. All residents will continually be reviewed during IDT meetings for lab and x-ray appointments and results. Auditing and monitoring at care conferences, and during weekly IDT meetings to ensure if lab/xray results have been communicated to the residents, and	

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F 552	Continued From page 3 R19's progress notes dated 1/3/24 at 7:07 a.m., HUC-A indicated lab results per certified nurse practitioner (CNP)-C, labs reviewed, CNP-D notified, and can decide if he wants any further referral based on patient hand pain symptoms. R19's document of X-ray results dated 12/28/23, indicated finger arthritis, document included signatures of HUC-A and licensed practical nurse (LPN)-A dated 12/28/23. R19's document of lab results dated 1/2/24, indicated CNP-C received and reviewed R19's lab/test results and CNP-C indicated labs reviewed, CNP-D notified and can decide if he wants any further referral based on patient hand pain symptoms, the document was dated 1/3/24 and signed by HUC-A. During an interview and observation on 1/8/23 at 5:30 p.m., R19 was seated in her room and stated she had labs and x-rays done a week or two ago and has asked numerous nursing staff the results and stated she had not received the results or heard from the doctor. R19 stated she would like to know the results of her blood work and X-ray of her right finger as it continues to cause her pain, swelling, and stiffness. Observed R19 attempt to bend her right hand index finger and observed the knuckle and finger swollen and difficulty bending her finger. R19 further stated the pain, swelling, or stiffness had not worsened. During an interview and observation on 1/9/24 at 3:40 p.m., R19 stated right index finger continues to be stiff and sore and the goes into the knuckle. R19 stated she asks nursing staff daily about the results of the blood work and X-ray that was	F 552	or family, and if they have questions will be done by DON or designee 3x week (T, W, and Th) for 4 weeks, 1x weekly for 4 weeks, and 2x monthly for one month with results being reported to QAPI.	

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F 552	Continued From page 4	F 552		

completed a week or more ago, and has not had a response. R19 stated she has not had the same nurse to be able to follow up with the previous nurses she has requested the results from.

During an interview on 1/9/24 at 4:34 p.m., the director of nursing (DON) stated when lab and X-ray results were received via fax, the HUC was expected to notify the nurse and the nurse should notify the resident of the results. The DON stated the nurse was expected to document when a resident was notified of lab or X-ray results.

On 1/10/24 at 8:08 a.m., registered nurse (RN)-C stated the facility practice was when lab results returned to the facility via fax the HUC notifies the nurse and the nurse signs off on the paper results and and places the results in the residents paper chart. RN-C confirmed the nurse would be responsible for informing and updating the resident of the results.

On 1/10/24 at 8:16 a.m., HUC-A stated lab or X-ray results are received via fax, and the HUC will sign off on the results and place the results in the resident's paper chart and leaves a colored tab that notifies the nurse to sign off on the results. HUC-A stated the nurse was responsible for updating the resident and family regarding results.

On 1/10/24 at 8:44 a.m., RN-D stated today R19 mentioned that she had lab and X-ray awhile ago and had not received results. RN-D stated she was not sure what the labs or X-ray results were for and would have to follow up with the DON.

On 1/10/24 at 12:35 p.m., during a follow up

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F 552	Continued From page 5 interview the DON stated the provider was expected to follow up with the R19 regarding X-ray and lab results, however would expect the nurse to follow up and contact the doctor when R19 requested the results. The DON further stated staff should have been aware of R19's previous requests of wanting her results of lab and X-rays, the DON further stated with the inconsistent staff the notification could possibly be overlooked. The DON was unaware R19 had expressed wanting to be notified of the results and expected nursing staff to contact the provider when a resident requested lab results The facility Health, Medical Condition and Treatment Options, Informing Residents policy dated 2/21, indicated Policy Statement: Every resident is informed of his or her total health status, medical condition and options for treatment and/or care. Policy Interpretation and Implementation: 1. Each resident is informed/of his/her health status and medical condition, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also informed. 2. The resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of his or her medical condition. 3. The person informing the resident/representative of his or her medical condition is required to present such information a format, language and cultural context that the resident/representative can easily understand. This includes, but is not limited to: a. communicating in plain language; b. explaining technical and medical	F 552		

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F 552	Continued From page 6 terminology in a way that makes sense to the resident; 4. Information about the resident's health status is presented at times that are convenient and useful for the resident/representative such as when he or she is asking questions, raising concerns or when a change of treatment is proposed.	F 552		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to	F 565		2/5/24

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F 565	Continued From page 7 participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 11 residents (R10, R11, R13, R15, R16, R32, R43, R45, R46, R50, and R57) who attended resident council. Findings include: Review of the 10/6/23, 11/7//23, and 12/12/23, resident council meeting minutes identified residents (R10, R11, R13, R15, R16, R32, R43, R45, R46, R50, and R57) voiced concerns regarding perceived lack of adequate staffing. There were no follow-up notes, in the subsequent resident council meetings regarding any action to be taken by the facility or any resolution. On 1/9/24, at 2:45 p.m. meeting was held with surveyor and resident council members R13, R15, R43, R45, R46, R50, R57 in attendance. Residents stated the council group met on a monthly basis and specific departmental concerns were discussed and departments failed to address or respond to any concerns or questions the residents present. During meeting R43 identified concerns with staffing and no follow up by the facility.	F 565	F565 St. John's has and always will ensure that each resident has a right to organize and participate in resident groups in the facility. An ad hoc resident council group (all were invited and not all attended) met on 1/18/2024 at 1 pm to ask how resident council format can be improved to ensure consistent communication on follow-up from their meetings. Policy and procedure Resident Council was reviewed on 1/15/2024 and updated to reflect that minutes will be taken, and each department will address area of responsibility within a reasonable time frame. The minutes will be reviewed at the next meeting. An updated agenda has been built by 1/10/2024 and initiated immediately. Department head and activity staff will be educated on this policy by 1/15/2024. Auditing and monitoring of the resident council minutes by Administrator or designee for follow-up will occur monthly	

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F 565	Continued From page 8 Interview on 1/9/23, at 3:10 p.m., with R43 identified grievances were not acted upon promptly by the facility and no resolution was offered. "We have asked and complained about staffing issues and they never get back to the council about what's being done about it. The communication is lacking and needs to improve." . Interview on 1/10/23, at 10:57 a.m., with activities director (AD) stated that she reviews, edits, and forwards the minutes to the director of nursing (DON) who taken forwards any concerns to the department supervisors. The AD indicated nursing and activities were responsible for follow up back to the residents. The AD confirmed the facility had no system to follow up with the concerns expressed from one meeting to the next and discussed going forward the process would change to follow up with the residents' concerns discussed during resident council. Interview on 1/10/24 at 11:54 a.m., with DON identified she was aware of resident concerns expressed at resident council meetings regarding staffing. The facility was working on hiring more staff. The DON further stated that she does follow up with department supervisors for resolutions but acknowledge there is not a formal process to inform residents or the resident council of updates, solutions, etc. That information had not been shared with residents at a council meeting, but it should have been in order for resident council to be aware of action taken to address their concerns. Interview on 1/10/23 at 12:11 p.m., with administrator acknowledged the lack of a formal	F 565	x6 months with results being reported to QAPI.	

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F 565	Continued From page 9 process to follow up on the resident's concerns after they are addressed by department supervisors and administrators. The A stated that either herself or the DON will speak with, either in person or via email, with department supervisors regarding concerns, resolutions, outcomes, etc. The A further stated that resident's concerns are important so the facility will improve communication, add old business to meetings and meeting minutes, to address better follow through. The facility Resident Council policy dated 1/10/24, identified the purpose of the resident council was to provide a forum for discussion of concerns and suggestions for improvement. Questions and concerns raised at the meetings shall be noted in the minutes and a response from the appropriate department head shall be sought by the next meeting.	F 565		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		2/5/24

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F 686	Continued From page 10 by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 2 of 2 resident (R71, R68) who developed pressure ulcers. The facility failure resulted in R71 sustaining harm when the resident developed an unstageable pressure ulcer to left gluteus (butt cheek) along with three additional stage II pressure ulcers on gluteus. Findings include: Pressure Ulcer stages defined by the Minimum Data Set (MDS) per Center Medicare/Medicaid Services: Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) Unstageable pressure ulcer: (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.) R71's Record of Admission, printed 1/10/24, indicated admission to the facility on 11/14/23, with diagnoses per the Diagnosis Report Sheet including: end stage renal disease with dependence on renal dialysis, orthopedic aftercare after acquired absence of right great toe and other right toe (1st and 2nd toes), reduced mobility, diabetes mellitus, heart failure, anemia (deficiency of health red blood cells in blood), morbid obesity (excessive body fat), and urgency of urination.	F 686	F686 St. John's has and always will ensure that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers and don't develop pressure ulcers unless they are unavoidable. R68 wounds were reassessed immediately, including a full skin check, by DON or designee on 1/11/2024. The care plan was updated on 1/17/2024 to include turning and repositioning, to ensure healing and the potential for future occurrences. R71 Wound assessment was done on 1/10/24 by DON or designee. R71 went to the emergency room on 1/11/2024 and was admitted on 1/12/2024. Upon her return, 1/19/2024, a comprehensive wound and skin assessment were completed and education about wounds and off-loading, turning/repositioning with resident by DON or designee to ensure an appropriate plan of care is being followed to best alleviate current wounds and the potential for future occurrences. High protein supplement was added on 1/31/2024. All interventions and care plan were reviewed and updated on 1/31/2024 by the DON. All other like residents were reviewed and assessed, if necessary, by DON or designee, on or before 1/19/2024 with no concerns noted.	

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F 686	Continued From page 11 R71's Admission Nursing Comprehensive Skin Assessment dated 11/14/23, indicated Braden Risk score (a scale that measures the risk of developing pressure ulcers) of 13 which indicated a mild risk. Other risk factors included assistance with activities of daily living, non-compliance with diet, fluids, mobility, head of bed elevated majority of the day and psychotropic drug use. Skin conditions and treatments included bruises, and surgical wound. Assessment of potential problem areas was blank. Areas found on assessment included abrasion on left gluteal fold 4 centimeter (cm) x 1.2 cm, bruises and incision from amputation on right foot. No additional comprehensive skin assessments were completed per electronic medical record. R71's Wound Assessment completed by licensed practical nurse (LPN)-D on 11/17/23 at 12:21 p.m., included a left gluteal fold wound present on admission and identified as other non-pressure wound. Contributing factors included resident is incontinent. Wound is 4 cm x 1.2 cm with no tunneling or infection present. Nursing interventions included "other" and under treatment identified R71 was placed on the nurse practitioner board for orders. There was no indication the provider was notified of the new wound and change in skin condition R71's admission Minimum Data Set (MDS) dated 11/20/23, indicated R71 had intact cognition, understood and understands, requires partial to moderate assistance with rolling left and right and lying to sitting on the side of bed and dependent with ability move from sitting on side of bed to lying flat on the bed. R71 was depend on all transfers. R71 was occasionally incontinent of stool and was continent of urine. R71 is at risk of	F 686	Policy and procedure Pressure injury policy/procedure and Skin Assessments were reviewed on 1/10/2024 with no changes needed. C.N.A and Nursing staff were trained and educated on these policies and procedures, on or before 1/19/24 by DON or designee. Any staff not trained and educated will be not allowed until completed. Auditing and monitoring of weekly skin check on eMAR, and all new admissions from 1/20/2024 and forward, will be done by DON or designee daily, M-F for 4 weeks, 1x weekly for 4 weeks, and 2x monthly for one month with results being reported to QAPI.	

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F 686	Continued From page 12 developing PU and currently has no PU's but does have a surgical wound. Skin and ulcer treatments included a pressure reducing device for the bed and surgical wound care. A progress note 11/21/23 at 2:54 p.m., by dietary manager (DM) included appetite was not good at times and has chewing, swallowing, taste changes and mouth pain. R71 is not on a supplement at this time. R71's Braden Scale (standardized assessment tool used to assess and document risk for developing pressure injuries) was completed on 11/23/23, with a score of 15 indicating mild risk for skin breakdown. Although the Braden Scale assessment indicated mild risk, the skin assessment indicated risk factors of impaired mobility, cardiovascular disease, end stage renal disease, obesity, diabetes and requires assistance with ADLS. R71 also had a gluteal abrasion on admission. In addition, there were other discrepancies between the assessments. The MDS indicated resident was continent of urine, progress notes indicated R71 required assist of one changing incontinent pads and was incontinent of loose stools. R71's plan of care dated 12/4/23, included R71 was at risk for alteration in skin integrity bruising, skin tears related to impaired mobility, multiple medication problems, diabetes, dialysis, obesity, occasional incontinence, anticoagulant therapy and requires assistance with ADL's. The care plan also included alteration in skin integrity related to surgical wound from right 1st and 2nd toe amputations on 11/2/23, and dialysis access site of right upper arm. Interventions included: Monitor for breakdown with cares and bath.	F 686		

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F 686	Continued From page 13 Mobility per care plan. Use pressure reducing measures as needed. Lower head of bed, and keep bedding wrinkle free. Toilet per care plan, lotion to dry skin with cares. Dietician to evaluate nutrition status as needed and encourage adequate fluid and food. Treatment to surgical wound per medical doctor (MD) orders. Update provider if concerns noted. Monitor for bruising and bleeding. On 1/3/24 an alternating air mattress and pressure reducing wheelchair cushion was added. The care plan failed to direct staff on the frequency for R71's repositioning, transferring or toileting plan to reduce the risk of pressure ulcers. On 12/6/23, Butt paste (topical medication for diaper rash and skin irritations) was ordered four times a day as needed to irritated peri rectal area and inner thighs from nurse practitioner (NP)-D. On 12/10/23 at 11:16 p.m., a progress note by LPN-C indicated wound open area of right inner thigh, and on left medial buttock measure 2.5 x 2 cm and wound on right medical buttock measuring 1.5 cm by 1 cm and 0.8 cm depth. Also has an unstageable ulcer on lateral left buttock measuring 2.5 cm x 3 cm. Hydrocolloid dressing was applied to areas on buttocks and zinc oxide (butt paste) applied to area on inner thigh. Review of the medical record lacked notification to the provider regarding the development of PU and no new interventions were initiated . A Wound Assessment dated 12/10/23 at 11:24 p.m. by LPN-C included: an unstageable PU on left lateral buttock, not present on admission. Eschar (dry, hard, leathery tissue that is not part of wound healing process and must be removed	F 686		

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F 686	Continued From page 14 to support healing) present over 90% of wound bed and full thickness. Contributing factors included non-compliance, personal habits, non weight bearing, in bed most of the day with limited offloading (technique used to protect wounds from getting worse due to added weight on the area). Wound is 2.5 x 3 cm with no tunneling and 90% eschar present with pink wound edges. Nurse interventions included chair cushion. Current wound treatment indicated R71 was placed on nurse practitioner board to be addressed at next visit. On 12/14/23 at 1:47 p.m., a progress note by NA-B, also identified as health unit coordinator, included "a wound unstagable pressure ulcer to left lateral buttock 2.5 x 3 cm with 90% eschar. Also has open areas bilateral medial buttock with left 2.5 cm x 2 cm and right 1.5 cm x 1 cm and 1.5 and 0.8 cm. and hydrocolloid dressing applied. Recommendations included dressing order please. Physician orders were okay for Mepilex to areas and to change every 3 days and as needed and to be discontinued to when healed." On 12/23/23 at 1:05 a.m., a Wound Assessment by registered nurse (RN)-F indicated right gluteal fold, pressure ulcer stage 2. Appearance of wound indicated area difficult to measure, reddened friable tissue with some open macerated areas on right gluteal fold. A second wound on left gluteal fold identified as PU, stage 2 with measurements of 1 cm x 0.5 cm with 100% slough present and some maceration and friable tissue noted surrounding the wound. A 3rd wound on left lateral buttock identified as PU, not staged and documented as not applicable (NA). Wound is 0.5 cm x 0.75 cm with no tunneling	F 686		

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F 686	Continued From page 15	F 686		

present. A fourth wound identified on left center buttock indicated PU and unstageable related to eschar, slough. Wound is 4 cm x 4 cm x 0.3 depth. Unable to determine if tunneling is present without debridement. Slough was 85% with eschar present for 15% of wound around edge. Nursing comments included frequent incontinent loose stools. Resident placed on nurse practitioner list for review of possibly adding pressure reducing mattress for resident. Although an additional wound was identified, no additional interventions were added at this time. The director of nursing (DON) reviewed and signed wound assessment on 12/28/23.

On 12/29/23 a Braden scale was completed with a score of 14 which indicated moderate risk for skin breakdown. No additional interventions were added.

A Wound Assessment dated 1/1/24 at 12:40 p.m. by LPN-D included right buttock PU stage 3 not present on admission. Wound was 1 cm x 1 cm with depth 0.3 cm. Drainage was present and surrounding tissue was red. A second wound included left buttock which was not present on admission and was PU stage 3. Medical provider was checked as being notified, but there was no indication the medical provider had made any changes or comments about R71's PU.

A progress note dated 1/4/24 at 3:01 p.m., by NA-B indicated "right wound was 4 cm x 4 cm, granulation with slough covering wound bed with moderate drainage. Bloody and odorous. Severe pain present and current treatment not effective. Wound clinic appointment not until January 24th this month. Nurse Practitioner (NP)-D ordered collagen, Zeroform and Mepilex to be completed

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F 686	Continued From page 16 every other day and as needed." A progress note 1/5/24 at 3:35 p.m., indicated registered dietician (RD) was consulted due to R71's skin breakdown on buttock region. R71 continued on therapeutic diet, a new weight was requested due to fair to poor appetitive at times. Nutritional supplement provided at dialysis when available. RD recommend a high protein healing supplement to support wound healing and protein levels. Although a progress note on 11/21/23 at 2:54 p.m., by dietary manager (DM) identified poor appetite and concerns of chewing, swallowing, taste changes and mouth pain. There was no indication any nutritional changes were completed even though she was admitted to the facility with a pressure ulcer on 11/23. R71's significant change MDS dated 1/5/23, indicated R71 has 1 unhealed PU, and 2 stage 3 PU's not present on admission. A pressure reducing device for chair and bed is present and turning and repositioning program. R71's Care Area Assessment (CAA) dated 1/5/23, indicated R71 is at risk for PU's and requires staff assistance to move sufficiently to relieve pressure over any one site. R71 is confined to bed or chair all or most of the time. R71 needs special mattress or seat cushion to reduce of relieve pressure and requires regular schedule of turning. Observation and interview 1/8/24 at 1:42 p.m., R71 stated she has a PU from laying on the bars of the bed. R71 added she could feel the bars on her buttock, in the area of sores. She could feel the bars through the mattress. R71 stated she didn't have a wound when she came here and at	F 686		

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F 686	Continued From page 17 the hospital they were putting a protective heart shaped dressing on her bottom but they didn't do that here. She has a dressing on it now that she has an open area and has an appointment on 1/24/24 to see wound care. R71 stated "I don't think it is very deep but deep enough". R71 was laying on her back in the bed with head of bed (HOB) at 30 degrees. R71 indicated she turns herself in the bed without assistance from staff but sometimes has to call for help to get a pillow tucked behind her to keep her on her side. R71 has an alternating air mattress present on her bed. Observation and interview 1/8/24 at 5:38 p.m., LPN-B indicated R71 had a loose bowel movement (BM) and her dressings came off her buttocks. At 5:51 p.m., R71 rolled to her left side with partial assistance from LPN-B and used the grab bar to keep herself in position. One dressing on mid left gluteal area remained intact. Wounds without dressings were measured and described by LPN-B and included: -Right gluteal area measured 0.5 centimeter (cm) by 0.5 cm. Slough (non-viable tissue) was present on wound bed. -Left lateral gluteal area 0.75 cm by 1 cm with slough present. -Left gluteal fold measured 1 cm by 0.75 cm with slough present. -Left mid gluteal area dressing was removed by LPN-B who described a moderate amount of white with brown tinged drainage present, which had a slight odor. LPN-B cleansed the wound with saline and 4x4 gauze pad and indicated the skin was red around the wound bed area. Measurements were completed and were 6 cm by 5 cm with a 1 cm hole in upper left portion of the wound. LPN-B indicated there is tunneling	F 686		

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F 686	Continued From page 18 present but did not attempt to measure the tunneling. LPN-B indicated this was an unstageable PU due to wound bed being covered with slough. Collagen powder (healing gel that keeps out bacteria) was applied to all 4 wounds, Zeroform (non adhering dressing) placed then Mepelix (highly absorbent form dressing) covering. LPN-B was unsure if the wounds were improved or worsened as this is her first time changing the dressings. R71 indicated there was some discomfort with changing of the dressings but otherwise she tries to position herself so she is comfortable. Observation and interview 1/9/24 at 3:28 p.m., with R71 indicated she had just returned from dialysis and was sitting in her wheelchair with her head in her hands. R71 indicated she is always tired after dialysis and her blood pressure was low again during dialysis. R71 indicated she had diarrhea this morning so took Immodium (medication used to treat sudden diarrhea), and only passed gas during her dialysis today. R71 indicated when she is at dialysis if she has a loose stool, she will just wait until she gets back to the facility to be changed because she can see how busy the staff are and doesn't want to bother them. R71 indicated at dialysis she can lay down in the chair or can sit up and controls that herself. R71 indicated no one has educated her to try to stay off her buttock or not to sit for long periods of time and generally will try to find a position that is the most comfortable. At 3:50 p.m., NA-A and NA-E entered the room and using a lift assisted R71 to her bed. R71 was then lying on her back with HOB at 20 degrees. Interview 1/9/24 at 4:00 p.m., nursing assistant (NA)-A indicated R71 is capable of turning herself	F 686		

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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 686	Continued From page 19 so is not on a turning program but sometimes will call for assistance if incontinent. NA-A indicated they use a lift to transfer her to her wheelchair for dialysis and upon return but she rarely gets into a chair per her request. During interview on 1/9/24 at 3:55 p.m., LPN-A indicated she was not aware R71 had PU's but it should all be documented in her medical record. LPN-A was not aware of any offloading program or of the wound care treatment but indicated she could look that up in the medical record if needed. During observation on 1/10/24 at 7:11 a.m., R71 was lying in bed and appears to be lying on her back with HOB flat. During interview on 1/10/24 at 9:20 a.m., NA-I indicated R71 is able to turn and reposition herself independently and will call for assistance if needed. NA-I indicated staff use a lift when she needs to get out of bed, otherwise she uses a bed pan. During interview on 1/10/24 at 10:44 a.m., medical doctor (MD)-B indicated she wasn't aware that R71 was so immobile and believed she was able to bear weight on her good leg and should have been more active. MD-B indicated R71's immobility put her at a higher risk for developing pressure ulcers along with incontinent liquid stool. MD-B stated "the skin breakdown isn't unexpected, but the severity was preventable". MD-B added interventions should have been put into place once a PU was identified to prevent further breakdown not just wound treatment. MD-B indicated she had not seen R71's PU's.	F 686		

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F 686	Continued From page 20 During interview on 1/10/24 at 11:05 a.m., R71 again indicated she repositions herself and staff do not come in to assist unless she calls for help. R71 indicated initially on admission she layed on her back a lot because her surgical wound on her foot had to be elevated. R71 indicated the first time she actually stood up was 2 days ago when therapy assisted her. R71 stated she rarely sits in the chair due to being incontinent of diarrhea and finds it easier to, with assist from staff, to use the bed pan if she is in the bed. R71 denied every refusing to reposition in the bed. R71 added she hasn't had a shower or bath since she was admitted due to her surgical wound needing to be closed with scab off prior to any bathing. R71 did indicated she has had all bed baths. During interview on 1/10/24 at 11:25 a.m., NP-D indicated skin breakdown wasn't completely unexpected but the severity should have been prevented by off loading pressure. NP-D indicated once one wound was identified the facility should have done more to prevent the other three from developing. NP-D indicated the facility has to make sure R71 is truly offloading if they aren't doing that currently and not just rely on R71 to turn herself. NP-D added he was aware of the wounds, but not the severity or of any tunneling and added he has not seen the wounds. During interview on 1/10/24 at 10:00 a.m., the DON confirmed R71 should have been put on an off loading schedule and the staff are responsible to ensure offloading is being completed. The DON confirmed education with R71 should have occurred with importance of offloading and repositioning. The DON confirmed R71 was on a regular facility mattress, which are supposed to prevent skin breakdown, until the air mattress	F 686		

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F 686	Continued From page 21 arrived on 1/4/24. The DON added the plan of care did not include a repositioning program and no new interventions were put in place prior to or after initial PU's were identified. R68's Diagnosis Report printed on 1/11/24, included hemiplegia (partial paralysis on one side of the body) following a stroke, protein-calorie malnutrition, anemia, and end-stage renal disease requiring dialysis. A PU was not included in the admission diagnoses from 8/11/23. A PU of sacral region, stage II, was added on 12/20/23. R68's comprehensive skin assessment dated 8/11/23, was completed upon admission. The assessment indicated R68 had a Braden risk score of 15, indicating mild risk for PU development. The skin assessment indicated R68 had a "red coccyx;" no open lesions and no current PU. The form indicated weekly, and PRN skin assessments were to be completed, to notify the provider of concerns, and to remind and assist R68 to off-load buttocks. Weekly skin assessments and off-loading had not been added to R68's care plan or orders. R68's admission Minimum Data Set (MDS) assessment dated 8/17/23, indicated R68 was cognitively intact; could understand and be understood. R68 was at risk for PU development, but had no unhealed PU's. R68 was dependent upon staff for most activities of daily living (ADL's). R68's care plan dated 8/22/23, indicated R68 was at risk for alterations in skin integrity due to impaired mobility, incontinence, and multiple medical issues. Interventions included monitoring	F 686		

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F 686	Continued From page 22 [skin] for breakdown with cares/bath. Lower head of bed to decrease friction/shearing, wrinkle free bedding. In addition, R68's care plan indicated R68 had impaired physical mobility related to weakness. Staff were to reposition R68 every two hours when in bed or chair. Further, staff were to assist R68 per her request for transferring, wiping, and pericare after incontinence. Progress note dated 9/24/23, indicated R68 had an open area to coccyx measuring 2.3 x 1.5 cm (centimeters). Abd (abdominal) pad applied for protection; resident off-loading with pillows while in bed. During document review, the next time a skin assessment was documented was on 9/24/23, six weeks after admission and when R68 returned from a seven-day hospitalization. The skin assessment indicated R68 had an open area to the coccyx measuring 2.3 x 1.5 cm, and the open area had been acquired before admission. This conflicted with the admission skin assessment conducted on 8/11/23, which indicated a red coccyx -- no open skin. The skin assessment form indicated staff would continue weekly and PRN skin assessments, weekly wound assessments, and would update the provider with any changes. The weekly skin assessments had not been added to the care plan or orders. R68's physician orders dated 10/3/23, indicated wound care: Mepilex foam dressing, every shift change, every three days or PRN (as needed) for open area to coccyx. Documentation of skin assessments varied regarding whether R68 had a PU to the coccyx at the time of admission or if it was acquired after	F 686		

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F 686	Continued From page 23 admission: --An admission comprehensive skin assessment dated 8/11/23, indicated a "red coccyx." No open lesions, no current PU. --The admission MDS dated 8/17/23, indicated no unhealed PU's. --A comprehensive skin assessment dated 9/24/23, indicated the open area on coccyx was acquired before admission. --Wound assessment flowsheets dated 9/26/23, 10/23/23, 11/2/23 and 1/10/24, indicated the wound was present upon admission. --Wound assessment flowsheets dated 11/15/23 and 1/8/24, indicated the wound was not present upon admission. A total of eight skin assessments had been documented from admission on 8/11/23 to 1/10/24, and conducted by five different nurses. During an observation and interview on 1/8/24 at 3:57 p.m., R68 was lying in bed with the head of the bed elevated approximately 30-45 degrees. R68 had a naso-gastric (NG) tube in place, not attached to a supplemental feeding. An alternating air pressure mattress was observed on the bed. R68 stated she had a PU on her bottom which was acquired after she moved into the facility on 8/11/23. R68 admitted she usually rested in bed in her current position - supine with head of the bed elevated. During an observation on 1/10/24 at 8:41 a.m., with registered nurse (RN)-B, observed R68's PU to coccyx. The PU was a pink circular wound, approximately the size of a quarter on the coccyx. The skin appeared in intact, no exudate, no odor. RN-B measured the PU to be 2 x 2 cm and stated it was healing well.	F 686		

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F 686	Continued From page 24 During an interview on 11/10/24 at 8:57 a.m., RN-B stated R68 had been admitted to the facility on 8/11/23, and arrived with a red coccyx but did not have open areas on her coccyx. RN-B, while looking in the electronic medical record (EMR) stated the first time an open area to R68's coccyx was documented was on 9/24/23. The first note by a provider regarding the open area was on 10/3/23, nine days after it was observed by nursing staff. During an interview on 1/10/24 at 10:57 a.m., medical doctor (MD)-B, who was familiar with R68, stated R68 would be at risk for PU development due to co-morbidities and that she would expect regular skin monitoring and repositioning for any resident who had mobility issues. MD-B was not able to say if R68's PU had been preventable. During an interview on 1/10/24 at 11:05 a.m., the director of nursing (DON) stated since R68 had a red coccyx upon admission, she would have been at risk for skin breakdown. The DON stated once staff identified the red coccyx, staff should have put an order in the EMR for weekly skin monitoring, and a provider should have been informed of any skin concerns. The DON admitted these actions had not been taken. The DON admitted no skin monitoring or assessments had been documented between R68's admission on 8/11/23 and 9/24/23, when the PU was discovered. The DON stated the care plan should have included something about monitoring bony prominence's, education on importance of repositioning. The first progress note identifying a provider was aware of skin concerns was on 10/3/23, and treatment orders were received. It was possible the PU was	F 686		

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F 686	Continued From page 25 acquired during hospitalization from 9/16/23 to 9/24/23, however, not able to determine this since the only documentation of R68's skin on 8/11/23, indicated a red coccyx, no open skin. An After Visit Summary from the hospital dated 9/24/23, did not mention skin concerns or PU's. The facility Skin Assessment protocol dated 2/17/20, included: -Weekly full head to toe skin assessment must be completed on the resdient's bath day indicted on the bath schedule. Skin assessment should be charted under bath/skin note in the progress notes. - Skin assessment needs to include: - Color of the skin and any redness. Redness over a bony prominence is present indicate whether it is blanchable or not -Skin integrity/any breakdown -All bony prominence's scapula, sacrum, heels, elbows, occiput, ankles, knees, hips and ears -Wounds and bruising new and existing. Include location, measurements, color, how the resident thinks the got it, any intervention and if there is any pain or swelling. Follow-up on wounds and bruising noted in previous skin assessment. A Pressure Injury policy and procedure last revised 9/19, included: - Upon noticing a pressure injury, complete a Wound Assessment and Braden scale. - Add an order to complete a Wound Assessment in the EMAR weekly -Start interventions as ordered/needed -Notify MD or in house NP of new pressure injury -Noisy family of new PU	F 686		

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F 686	Continued From page 26 -Notify dietary of new pressure injury -Consult MD or in house NP, nurse manager, visiting wound nurse or wound clinic as needed for treatment -Complete a new Wound Assessment weekly -Document weekly and as needed in the nursing notes on size, drainage, odor, pain, surrounding tissue and current treatment -Review at interdisciplinary team meetings	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 2 of 2 residents (R23 and R40) reviewed for limited ROM.	F 688	F688 St. John's has and always will ensure residents do not experience a reduction in range of motion unless the residents clinical condition demonstrates that a	2/5/24

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F 688	Continued From page 27 Findings include: R23's Diagnosis Report sheet included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (poor blood flow to the brain causing cell death) affecting right dominate side, type two diabetes mellitus with chronic kidney disease, dementia, mild with mood disturbance and contracture (permanent tightening of the muscles, tendons, skin causing the joints to shorten and stiffen) of right hand. R23's quarterly Minimum Data Set (MDS) assessment dated 12/7/23, identified R23 as having a brief interview for mental status (BIMS) of "10" (meaning moderate impairment in cognition). R23 had no behaviors including rejection of care. R23 usually is understood and understands. R23 had impairment on one side of upper and lower extremities and required partial to substantial assistance with activities of daily living but totally depend for transfers. R23's care plan last reviewed 12/19/23, identified R23 as having impairment of physical mobility related to cerebral infarction affecting right side, history of fracture of femur, contracture of right hand and weakness and impaired balance. Interventions included: Per occupational therapy (OT), resting hand splint to right upper extremity on at night. May wear splint during the day per resident request. Passive range of motion (PROM) and stretching to right wrist and fingers per OT instructions twice daily, morning and night. An Occupational Therapy (OT) evaluation and treatment plan dated 10/3/23, indicated patient	F 688	reduction in range of motion in unavoidable. R23 has the appropriate equipment to maintain mobility in her right arm, although residents often refuse, and care plan has been updated as of 1/17/2024. R40 has the appropriate equipment to maintain mobility in the left hand and the care plan was updated on 1/18/2024. All like residents were reviewed for appropriate ROM services and assistance to maintain or improve mobility with updates to care plans on or before 2/5/2024. Resident Mobility and Range of Motion (ROM) policy and procedure was reviewed on 1/9/2024 by Administrator and DON with no changes needed. Nursing staff were trained and educated on this policy and procedure on 1/19/2024 by DON or designee. All residents will continually be reviewed during IDT meetings for the need for ROM and mobility assistance. Auditing and monitoring at care conferences, and during weekly IDT meetings to ensure Range of Motion, and PROM is being discussed will be done by DON or designee 5x week (M-F) for 4 weeks, 1x weekly for 4 weeks, and 2x monthly for one month with results being reported to QAPI.	

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F 688	Continued From page 28	F 688		

tolerates active and passive range of motion to right upper extremity joints. R23 has a resting splint in the past and stated she does not want to wear one of these. Patient tolerates a rolled up washcloth for up to 2 hours and then will take out. Patient agrees to wear a palm protector at night. OT wrote restorative nursing plan directions and communicated to staff and to patient wearing recommendations.

A Restorative Nursing Program dated 10/3/23, for R23, included please put right palm guard on patient at night. Monitor any redness or discomfort. Goal is to prevent skin breakdown and further contracture in right hand.

A treatment record, printed 1/10/24, indicated right hand arm splint apply for two hours after meals per therapy. Palm guard on every night, please assure palm is cleansed before apply at HS.

Observation and interview on 1/8/24 at 1:16 p.m., R23's was sitting in her wheelchair in room with fingers of right hand curled inwards toward her palm of her hand but fingernails did not put pressure on the palm. R23 indicated staff do not complete range of motion on her right hand or fingers. R23 said she will "play" around with her hand and fingers and demonstrated by grasping her right fingers with her left hand and tried to straighten them. R23 was able to open her fingers from her hand but was not able to straighten them. R23 stated they are getting stiffer. R23 stated she has worn a splint in the past but is not sure what happened to it and she would be willing to try wearing it at night.

Observation 1/8/24 at 7:20 p.m., R23 was in her

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F 688	Continued From page 29 bed with lights off. No palm protector on right hand. Observation and interview 1/9/24 at 10:49 a.m., R23 was in the hallway in her wheelchair. R23's right fingers remain curled inwards towards the palm of hand. Nothing on right hand except a right arm sleeve on lower and upper arm. Interview on 1/9/24 at 1:30 p.m., occupational therapist (OT) indicated she has not had R23 on her therapy list so isn't aware of treatment for R23's right hand contracture. Interview on 1/9/24 at 4:56 p.m., nursing assistant (NA)-A indicated R23 wears her splint (rigid or flexible device that maintains a position of a moveable part) off and on throughout the day. NA-A added they do try to complete ROM but R23 doesn't always allow it to be done. Interview on 1/9/24 at 4:59 p.m., NA-G indicated she was unsure about ROM or a splint for R23. Interview on 1/9/24 at 5:02 p.m., registered nurse (RN)-E indicated R23 should wear a splint after meals for 2 hours per the medical record. Observation and interview on 1/10/24 at 7:08 a.m., R23 was lying in her bed. Right arm has multiple Band-Aides present. No splint or palm protector (allows free finger movement and prevents nail to palm contact and skin breakdown of the palm) on her right hand. R23 indicated she did not wear a splint or palm protector during the night and did not refuse to wear one. Interview on 1/10/24 at 7:14 a.m., RN-E indicated the task list indicated R23 is to wear a splint for 2	F 688		

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hours after meals. RN-E was not sure what the plan of care says. RN-E was shown palm protector that was in R23's bathroom.

Observation on 1/10/24 at 8:31 a.m., NA-H indicated R23 used to have a blue splint but is unsure what happened to that. NA-H indicated she now wears a palm protector which is supposed to put on at night and if R23 wants to during the day also.

Interview on 1/10/24 at 9:45 a.m., the director of nursing (DON) confirmed the care plan, and treatment orders have varying treatments present and is unsure what R23 should be wearing at this time and will address this issue. The DON indicated therapy was instructed when writing restorative nursing recommendations to give her, the health unit coordinator a copy and put one in the residents packet outside of their room. The DON confirmed it is her responsibility to update the care plan, treatment orders and communicate any changes with staff.

R40's diagnosis report sheet included diagnoses of multiple sclerosis (MS) (inflammation to nerve fibers making it difficult for the brain to send out signals), dementia with agitation, and chronic kidney disease. contracture (permanent tightening of the muscles, tendons, skin causing the joints to shorten and stiffen) of right hand.

R40's annual MDS assessment dated 11/23/23, identified R40 as having a brief interview for mental status (BIMS) of "8" (meaning moderate impairment in cognition). R40 had no behaviors for rejection of care. R40 usually is understood and understands. R40 had impairment on one side of upper extremity and required partial to

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F 688	Continued From page 31 substantial assistance with activities of daily living. R40's care plan dated last reviewed 9/12/23, identified R40 as having impairment of physical mobility related to MS, anemia, ...weakness, and dementia. Interventions included; left and right arm/hand exercises daily per instructions. Active and passive range of motion (ROM) program daily with the assist of staff. Assist with application of palm guards daily and remove at night. Monitor for appropriate positioning of hand as needed. An OT evaluation and treatment plan dated 11/10/23 indicated R40 tolerated roll to left upper extremity during the daytime and ROM was completed to left upper extremity active and passive to elbow, forearm, wrist, digits. A Caregiver Education sheet dated 10/27/23 included: Patient demonstrates ability to participate in left upper extremity active and passive range of motion program daily with the assist of staff. Program located in room. Please assist with donning palm guard daily and remove at night at this time. Monitor for appropriate positioning on hand as needed. Observation and interview on 1/8/24 at 12:29 p.m., R40 was sitting in a chair in room with fingers of her left hand curled inwards toward the palm of her hand with fingernails pushing on the palm of her hand. R40 was able to take her right hand and move her fingers away from the palm of her left hand. 3 red areas present in palm where fingernails had been. R40 indicated staff do not complete range of motion on her left hand or fingers but she can move them when she feels	F 688		

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F 688	Continued From page 32	F 688		

like it. R40 did not have a palm protector or roll in her hand.

Observation 1/9/24 at 11:28 a.m., R40 was in dining room in her wheelchair at a table. No palm protector on her left hand. Left hand fingers were curled into the palm of her hand.

Observation and interview 1/9/24 at 2:19 p.m., a family member (FM)-F indicated he placed the palm roll in R40's hand when he got here around 1:00 p.m. today because R40 did not have it in her hand. When questioned, FM-F indicated R40 would not remember to put it in herself and he frequently has to put it in her hand when he gets here. FM-F indicated he doesn't do any ROM on R40's left hand. FM-F indicated staff are supposed to do it, but he doesn't think it is happening at all.

During interview on 1/9/24 at 2:10 p.m., occupational therapy (OT)-A indicated R40 does not use a palm protector or splint but uses a roll (gauze pads wrapped with tape) that was made for her to wear as she refused anything else. OT-A indicated R40 is supposed to use the roll in her left hand during the day and she has exercises that are to be done on her left extremity daily. OT-A indicated R40 is currently receiving therapy services related to weakness and a fall but is not related to contracture of her hand.

Interview on 1/9/24 at 5:00 p.m., NA-A indicated R40 puts the roll in her hand and does her own ROM exercises.

Interview on 1/10/24 at 7:18 a.m. NA-I indicated R40's husband completes the ROM to R40's fingers and hands. R40 puts the roll in her hand

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F 688	Continued From page 33 and takes it out herself every day. During observation on 1/10/24 at 11:18 a.m., R40 was sitting in a chair in her room with her left fingers folded in towards the palm of her hand. No roll was present in her hand. Interview on 1/10/24 at 7:48 a.m., DON indicated she wasn't aware the palm guard was no longer being used and the roll was being used. The DON indicated she is responsible for updating the care plans but wasn't notified of the change. The DON indicated therapy was recently instructed when writing restorative nursing recommendations to give her, the health unit coordinator and one in the residents packet outside of their room. The DON confirmed if ROM is recommended from therapy it should be done by staff. The facility Range of Motion policy and procedure dated July 2017 included: - Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. -Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. -As part of the comprehensive assessment, the nurse will identify conditions that place the resident at risk for complications related to ROM including: -pain -skin integrity issues -muscle wasting and atrophy -contractures or other complications that could cause or contribute to immobility, impaired ROM or injury from falls.	F 688		

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F 688	Continued From page 34 -The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. -The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in and/or improve mobility and range of motion. -The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives.	F 688		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor and assess a resident for potential complications related to dialysis treatment and failed to ensure consistent communication with the dialysis facility for 1 of 1 resident (R71) reviewed for dialysis. Findings include: R71's facesheet printed on 1/10/24, included diagnoses of dependence on renal dialysis (a treatment for failing kidneys to remove fluid and waste from the blood), diabetes mellitus type two and anemia (deficiency of healthy red blood cells) in chronic kidney disease.	F 698	F698 St. John's has and always will ensure that residents who require dialysis receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. R71 went to hospital and was admitted on 1/12/24, she returned on 1/18/2024 with updates to nursing orders to reflect a pre and post dialysis evaluation/assessment on or before 1/31/2024. All other like residents were reviewed per	2/5/24

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F 698	Continued From page 35 R71's significant change Minimum Data Set (MDS) assessment dated 1/5/24, indicated R71 was cognitively intact, had clear speech, was understood and able to understand. R71 did not walk and required substantial to maximum assist with activities of daily living, partial to moderate assist with rolling, and was totally dependent for transfers. R71's care plan dated 12/4/23, indicated R71 was at risk for complications related to dialysis. Interventions included medications, treatments, diet, lab and dialysis per medical doctor (MD). Monitor for risks, such as infection, bleeding, hematoma (blood-filled swelling). Assess access site and bruit (sound heard with blood moving through a vessel) daily. Notify MD/dialysis unit of risks. No blood pressure on access extremity, right arm. If access site bleeds, apply direct sterile pressure with 4x4 gauze for ten minutes. If continues or blood is oozing from catheter site, notify dialysis unit/send to emergency department. If bleeding stops place Band-Aid and monitor. Dialysis does site care for chest catheter. Physician orders dated 11/15/23, included hemodialysis three times per week. Remove white gauze dressing before bed three times a week in the evening after dialysis. Another order dated 11/15/23 indicated remove Band-Aid from access site the morning after dialysis three times per week. A nursing order dated 11/14/23 indicated weekly weight on bath day every week. A provider order dated 1/3/24, indicated check weight on non-dialysis days 7-3 shift. During observation and interview on 1/8/24 at 1:26 p.m., R71 indicated her dialysis schedule is	F 698	hemodialysis policy and procedure and had nursing orders for a pre and post dialysis evaluation/assessment added 1/31/2024, or upon their return from the hospital. The Hemodialysis policy and procedure was reviewed and updated on 1/11/2024 by the DON and Administrator to include nurse on duty will document that they went into the residents' room after dialysis to complete evaluation/assessment. Training and education on the updated Hemodialysis policy was completed on 1/19/24 by DON or designee with all licensed nursing staff. Each resident on dialysis had their eMAR's updated, on or before, 1/31/2024, or upon their return from the hospital with pre and post dialysis evaluation/assessment. This includes communication with the resident during the evaluation/assessment. All residents will be discussed during IDT meetings to ensure the concern does not recur. When residents on dialysis go for their service, the following information is sent to the dialysis provider: physicians orders and diagnosis along with the "St. John's Lutheran Home Progress Notes from Dialysis form" for Dialysis to communicate to the facility about the resident. Auditing and monitoring of nursing	

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F 698	Continued From page 36 Tuesday, Thursday and Saturday. R71 indicated her fistula (a surgical connection between artery and a vein that allows blood to flow through it. It is preferred type of access for hemodialysis) is in her right upper arm and she removes the dressing after dialysis treatments before bed. R71 indicated she takes an orange folder to dialysis from the facility but is unsure what is in it. R71 stated when she comes back the nursing assistants (NA) assist her back to bed when they get time and she doesn't see a nurse until her medications are due and no assessments or vital signs are completed. R71 added the nurses don't look at her fistula site until bedtime or whenever they get time. During observation and interview on 1/9/24 at 11:08 a.m., R71 was observed not in the facility. NA-B indicated R71 was at dialysis treatment. During observation and interview on 1/9/24 at 3:25 p.m., R71 returned from dialysis in her wheelchair and was placed in her room. An orange folder was taken to the nurses station. by unidentified facility staff. R71 indicated her blood pressure was low again today during dialysis and "they didn't even take any water off, just cleaned my blood". R71 showed access site on right upper arm, which was covered by 4x4 gauze and paper tape. No drainage was present. R71 indicated staff do not check her fistula site when she returns but they do check it and listen once a day and confirmed she is the one who removes the 4x4 gauze dressing around 7 p.m. R71 indicated she tries to eat breakfast before she leaves for dialysis but it doesn't always happen. R71 added dialysis doesn't allow patient's to eat there. R71 stated she doesn't get offered a snack and she usually just waits until supper to	F 698	documentation after residents receive dialysis to ensure nurses are checking on residents on their dialysis days, for 4 weeks, 1x weekly for 4 weeks, and 2x a month for one month with results being reported to QAPI.	

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F 698	Continued From page 37 eat something. During observation on 1/9/24 at 3:50 p.m., nursing assistant (NA)-A and NA-E entered R71's room and using a mechanical lift and transferred R71 to her bed. NA-A indicated R71 usually is tired when she returns and wants to lay down. NA-A indicated if something "wasn't right" with R71 after dialysis, she would notify the nurse. NA-A indicated they do not do vital signs upon R71's return or look at her fistula site. During interview on 1/9/24 at 3:55 p.m., licensed practical nurse (LPN)-A indicated she had not assessed R71's dialysis access site since R71 returned and will remove R71's fistula dressing prior to bed time. LPN-A indicated there are no orders to do vital signs, or assess or check access site so she has not completed those things. LPN-A was questioned on what is sent with R71 to dialysis and LPN-A indicated she doesn't know what is sent with R71. During interview on 1/10/24 at 9:34 a.m., NA-B, also identified as health unit coordinator, indicated they send the St. John's Lutheran Home Progress Notes from Dialysis sheet with R71 to dialysis. NA-B indicated once in awhile the dialysis center will request an updated order sheet so that will get sent, but that is all that is sent with R71. The orange folder included a St. John's Lutheran Home Progress Notes from Dialysis. A note dated 1/9/24, from dialysis indicated pre and post weights both as 101.7 (did not include unit of measurement) and nurse practitioner was contacted by dialysis dietician asking that R71 be on an unrestricted diet and have Nepro	F 698		

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F 698	Continued From page 38 (nutritional shakes for people on dialysis) ordered for her. Additional entries on the progress notes included: 11/16/23 from dialysis indicated R71 is saying she has loose stools. Request she get Immodium (medication used to treat sudden diarrhea) prior to being sent to dialysis. 11/18/23 no issues 11/21/23 no issues, blood pressure 119/71 11/30/23 Start weight (wt) 108.4 kilograms (kg), Post treatment wt 105.8 kg. 12/2/23 Pre wt 108 kg, Post 107.4 kg. No issues 12/5/23 Pre wt 108 kg, post 107.2 kg. No issues 12/7/23 no complications No further documentation until 1/9/24. Entries were not signed by dialysis staff. During record review vital signs were completed 1/9/24 prior to dialysis with pulse 68, respirations 18, blood pressure 115/84 and blood sugar 87. Review of weights included 11/14/23, 249 pounds (pds), 11/17/23, 240.7 pds and 1/5/24, 218.1 pds. During interview on 1/10/24 at 10:00 a.m., the director of nursing (DON) indicated she would expect a progress notes for nurses to document on, a face sheet, medication list and what medications have been given to R71, and physician orders each time R71 goes to dialysis for dialysis team. The DON was unsure what dialysis should communicate upon return and indicated she would need to check further into that. The DON indicated she doesn't believe staff do an assessment or vital signs upon R71's return, other than checking the fistula site for bleeding. During interview on 1/10/24 at 11:05 a.m., R71 indicated she removed her fistula dressing last	F 698		

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F 698	Continued From page 39 evening herself. A phone call to dialysis was completed with message left and no return call received. A Memorandum of Understanding Mayo Clinic Dialysis Services Patients Who Are Residents in Long-Term Care Facilities/Nursing Homes included date and patient name which were both blank. The purpose of this document is to answer questions about dialysis patients and their unique needs. Routine questions can be sent by written communication with the patient to the dialysis unit. In general, questions of an urgent or acute natures should be phones to the dialysis unit charge nurse, who can then contact the nephrology provider. If bleeding from fistula site, apply direct pressure. Nursing home staff should call 911 immediately if bleeding time is more than 1-2 minutes or if the nurse is unable to control bleeding from the access. Vital signs should be performed as per routine for nursing home patients. Blood pressure cuff and tourniquet should not be applied to extremity with dialysis access. Blood pressure, weights, pulse and temperature will be determined during each visit to the dialysis unit. Redundancy with nursing home routine may be eliminated. The facility Hemodialysis policy and procedure undated, included: - Any resident receiving hemodialysis must have a service control/memo of understand with the dialysis facility. The contract is individualized to each resident and must be obtained with initiation of dialysis services. -Remove the resident's white gauze dressing before bed on the evening of his/her dialysis treatment.	F 698		

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F 698	Continued From page 40 -Remove the band-aids the next morning -If resident begins to bleed from access site,, apply direct pressure with sterile 4x4 for approximately 10 minutes. -If site continues to bleed continue pressure for another 10-15 minutes. -If site continues to bleed heavily, call the Dialysis Unit, or if closed sent resident to the emergency department. -If bleeding stops, put another band-aid over the site, and monitor periodically for further bleeding. *Prior to dialysis, staff to offer resident snack options and a meal following their appointment.	F 698		
F 880 SS=F	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. 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;	F 880		2/5/24

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F 880	Continued From page 41 §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 (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.	F 880		

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F 880	Continued From page 42 §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 Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19, failed to ensure appropriate use of personal protective equipment (PPE) when staff were observed not an wearing N-95 mask in the room of 1 of 1 resident (R20) in transmission based precautions (TBP) for Covid-19; failed to doff (remove) PPE per guidelines when staff were observed removing all PPE after exiting the room of a resident (R20) in TBP for Covid-19 for 1 of 1 resident (R20); failed to ensure precautions posted on resident room doors followed CMS and CDC recommendations for 1 of 1 resident (R20); failed to ensure all staff were fit-tested for use of N-95 masks; this had the potential to affect all 73 residents who resided in the facility. Findings include: Upon arrival to the facility on 1/8/24 at 10:40 a.m., a sign on the entrance door indicated masks were required and there was one case of COVID-19. During an interview on 1/8/24 at 10:45 a.m., with the registered nurse (RN)-A who identified as the infection prevention nurse, confirmed R20 was the only current COVID-19 case at the facility and was on TBP. RN-A explained all other residents on third floor had previously tested positive for COVID-19 and were out of isolation. RN-A stated	F 880	F880 St. John's has and always will maintain an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. R20 has recovered from COVID as of 1/10/2024. There is one like resident and the proper PPE, signage, and garbages available to staff. Staff Devel/IP and Administrator reviewed the MN Dept of Health PPE grid on 1/8/2024 and initiated N95's on the floor for the COVID positive residents. Communication to C.N.A's, LPN/RN's, and T.M.A's was done on 1/9/2024 to the update in policy, PPE usage to include N95, as well as doffing procedure, and garbage cans were placed inside the rooms. Training and education on policy updates, PPE usage to include N95, doffing procedures, and garbage cans were initiated with C.N.A's, LPN/RN's, and T.M.A's on 1/9/24 and is on-going.	

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F 880	Continued From page 43 masks were only required on third floor of the facility due to no other cases of COVID-19 the other floors. During an observation on 1/8/24 at 1:29 p.m., R20's door was closed, and a sign was posted and indicated enhanced respiratory precautions and instructed gown, facemask or N95 respirator for aerosol generating procedures and ICU care, eye protection, one pair of gloves. A PPE cart was located outside of R20's room and included disinfecting wipes, eye protection, gloves, regular medical grade face masks, gowns, and the cart failed to include N95 masks. Further, placed on top of the PPE cart included paper instructions for donning and doffing, the instructions failed to indicate N95 mask instructions. On 1/8/24 at 3:13 p.m., R20's room was observed, and no garbage was located inside R20's room to discard PPE prior to exiting the room. Outside of R20's room a clean PPE cart was observed closest to R20's door and next to the clean PPE cart was a garbage closet to the hallway. During observation and interview on 1/8/24 at 6:23 p.m., nursing assistant (NA)-A exited R20's room with gown, gloves, regular mask, and eye protection, walked past the clean PPE cart, then removed her PPE and discarded her PPE in the garbage located outside of R20's room next to the hallway. NA-A completed hand hygiene and placed a new medical grade mask on. NA-A stated she was not required to wear a N95 mask in R20's room, and stated she changed her mask after exiting resident rooms who were placed in TBP. NA-A further stated she would wear a N95 mask if provided by the facility, but the facility did	F 880	The policy and procedure for the Respiratory Protection Program was reviewed on 1/12/2024 by Staff Development/Infection Preventionist with no changes made. The medical director was contacted and is the reviewer and signor on required medical clearance forms. Medical clearance forms were added to new hire paperwork on 1/15/2024 and current staff medical clearance forms are being completed. Fit Testing has been initiated with C.N.A's, LPN/RN's, and T.M.A's with on 1/15/2024. All new hires with the potential for going into COVID positive rooms will be given medical clearance forms and be fit tested during the on-boarding process. Auditing and monitoring of COVID positive donning and doffing of PPE has been initiated on 1/18/2024 and is on-going with results being reported to QAPI. Random audits on PPE usage will be completed 3x weekly for 1 month, weekly for 4 weeks, and 1x monthly for 3 months with results being reported to QAPI.	

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	245635	A. BUILDING _____ B. WING _____	C 01/10/2024

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F 880	Continued From page 44 not provide staff with N95 masks and were not available in the PPE cart. During observation and interview on 1/8/24 at 6:23 p.m., NA-C donned PPE including gown, gloves, eye protection, and regular medical grade face mask and failed to wear a N-95 mask and entered R20's room. NA-C was observed in R20's room and seated next to his bed and and assisted R20 with his meal and wore a regular mask. NA-C stated she would like to wear a N95 mask, but the facility did not provide the N95 masks, and confirmed there was not garbage inside of R20's by the door to discard PPE. NA-C stated the facility practice was to remove PPE after exiting the room of a resident on TBP. During interview on 1/8/24 at 6:43 p.m., RN-A, also identified as infection preventionist, stated when a resident becomes positive for COVID-19 the facility posts a sign on the resident door that indicated enhanced respirator precautions and confirmed the sign did not include N95 mask. RN-A stated she was not sure when she found the sign she used, but stated it was found on the Internet from MDH (Minnesota Department of Health). RN-A was observed to search the Internet on her computer and found an enhanced respiratory precautions information and sign from MDH that indicated N95 respirator. RN-A stated she was not aware N95 were required and thought it was a recommendation versus a regulation. RN-A stated the N95 masks were not placed in the PPE carts for residents on TBP with COVID-19, however stated the facility did have N95 masks available, and further stated the facility had not done employee fit testing for N95 masks. RN-A stated staff were expected to doff immediately outside of the of COVID-19 TBP	F 880		

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F 880	Continued From page 45 resident rooms, and was not aware that doffing of gown and gloves should take place immediately inside of the resident room. During an observation on 1/9/24 at 11:08 a.m., R20's door was observed with different enhanced respiratory precautions sign from yesterday and indicated gown, N95 respirator or higher level respirator, eye protection, one pair of gloves and N95 masks were observed in the PPE cart outside of R20's room. During an observation and interview on 1/9/24 at 11:11 a.m., NA-D and NA-E exited R20's room with full PPE that included gown, gloves, regular mask, and eye protection, and removed PPE outside of the room. NA-D confirmed R20 was on TBP for COVID-19 and a N95 mask was not required, and stated the facility had not instructed her to wear an N95 mask when entering COVID-19 resident rooms. NA-D stated she had not had any fit testing at the facility. NA-D stated all PPE is taken off outside of R20's room. NA-E stated a N95 mask should be worn in resident rooms with COVID-19, and further stated she wore a regular mask because she cannot breathe with the N95 mask, and confirmed she was fitted for N95 mask at another facility. NA-E stated PPE should be removed inside of the resident room. During an observation and interview on 1/9/24 at 11:22 a.m., NA-F donned PPE and failed to wear a N95 mask and entered R20's room, at 11:26 a.m., NA-F exited the room with gown, gloves, eye protection and medical grade face mask and discarded all PPE outside of the room, completed hand hygiene and placed on new medical grade face mask. NA-F stated she had worked at the facility for two days and was in training, and	F 880		

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F 880	Continued From page 46 stated prior to today the N95 masks had not been in R20's PPE cart. NA-F further stated last week the facility had 11 residents in TBP due to COVID-19 and N95 masks were not worn. NA-F stated she would assume the N95 were expected to be worn since they were in the PPE cart, but she had not been educated to wear the masks, FIT tested or instructed on how to wear an N95 mask. NA-F stated facility practice was to remove all PPE outside of resident rooms. NA-F stated she also followed another employee and learned how to don and doff (take off) PPE from other staff members. On 1/9/24 at 11:51 a.m., RN-A stated she placed a new sign on R20's door that indicated N95 masks when entering R20's room, and placed N95 masks in the PPE cart. RN-A confirmed the facility or herself had not educated staff to wear the N95 mask, when entering resident rooms placed on TBP for COVID-19. On 1/9/24 at 12:10 p.m., during an interview the DON stated would expect staff to wear mask, gown, gloves, and face shield when entering a resident on TBP with COVID-19, and was not facility practice to wear N95 mask as was a recommendation. The DON stated she had been at the facility for a year and was not aware of any FIT testing that had occurred. The facility was not able to provide any documentation employees of the facility had been fit tested. The facility Isolation and Transmission Based Precautions policy dated 11/28/23, indicated: 3. Enhanced respiratory precautions are required for residents with known or suspected COVID-19	F 880		

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F 880	Continued From page 47 infection. Residents should be in a private room with the door closed and not share a bathroom. Because transmission requires close contact, a gown, face mask, or particulate respirator (for aerosol generating procedures), Eye protection and gloves are recommended to be worn by persons within six feet of the infected or suspected person. The facility Donning and Doffing PPE policy dated 1128/23, indicated Supplies: Gowns Face Mask or N95 respirator Eye protection-face shield or goggles Gloves Proper sequence doffing (Removing PPE.) PPE and caring for residents with confirmed or suspected COVID-19 (If the facility is following PPE, optimizing for extended or reuse, follow facility procedure: 1. Remove gloves, taking care not to contaminate hands. 2. The gown is removed next, removing the gown away from the body in a manner to prevent contamination. a. Roll down into a ball, ensuring the contaminated side is rolled inward. b. Dispose in waste receptacle. c. If reusable gown is used, once removed, placed in soil laundry container. 3. Perform hand hygiene upon exiting room 4. Once outside the resident room, remove eye protection (face shield or goggles) being careful not to touch the front of the shield or goggles. a. Sanitize eye protection with bleach or peroxide wipe. 5. Remove face mask by untying (or removing	F 880		

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F 880	Continued From page 48 ear loops) while being careful not to touch the outside of the mask. a. Dispose of face mask in waste receptacle. i. Place N 95 in paper bag for reuse with the same resident. b. DON face mask for universal masking 6. Perform hand hygiene.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/11/2024. At the time of this survey, ST JOHNS ON FOUNTAIN LAKE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 02/08/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST JOHNS ON FOUNTAIN LAKE is a 3-story building with partial basement. The original building was constructed in 2014, a three-story building with a partial basement and was determined to be of Type II (111) construction.	K 000		

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility.	K 374	K374 St. John's has and always will ensure doors are self-closing and rabbets, bevels, or astragals are required at the meeting edges.	2/8/24

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K 374	Continued From page 3 Findings include: On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that smoke compartment doors in the following locations, upon testing did not self-close and seal the opening: 3rd Floor adjacent to the elevator; 2nd Floor adjacent to the elevator; 1st Floor - 1D100C door set; and in the Basement at the transition between Building D and B. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	3rd Floor adjacent to the elevator, 2nd floor adjacent to the elevator, 1st Floor - 1D100C door set, and in the basement at the transition between Building D and B closures were adjusted for latching on 1/18/2024. Specific door gaskets were ordered on 2/7/2024 and will be placed on 3rd Floor adjacent to the elevator, 2nd floor adjacent to the elevator, 1st Floor - 1D100C door set, and in the basement at the transition between Building D and B as soon as they arrive at our location. Monthly, upon required door testing, latching for full closure and door gasket placement will be reviewed by EVS director or designee for 3 months with results being reported to QAPI.	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire	K 712	F712	2/8/24

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K 712	Continued From page 4 drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted for 1st Shift - Q1. 2. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that documentation for 3rd Shift in Q3 and Q4 were incomplete in data capture. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	St. John's has and always will ensure fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. Missed 2023 fire drill was conducted on 1/29/2024 and will be done monthly thereafter to meet regulations. After hours fire drills will be silenced and completed as required moving forward on the specific rotation when it is due. Monthly review of fire drill schedule will be completed during monthly meeting with Administrator to ensure variability for 6 months with results being reported to QAPI.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is	K 914		2/8/24

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K 914	Continued From page 5 performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to accurately document electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the documentation presented for review was incomplete in it capture of information related to the outlets in resident / client rooms. 2. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by observation in resident room RM105 only partial information related to the total outlet testing of the room was completed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	K914 St. John's has and always will ensure a consistent testing method is used to assure all recepticles are tested as required. All electrical receptacle testing will be done in the same manner to ensure no missed receptacles during testing using an updated form recommended by the fire marshall. Training and education will be done on the new outlet form 2/6/2024. The new tracking form will be implemented on 2/6/2024. Random audits by EVS director or designee will be completed 2x monthly for one month, and 1x monthly for 2 months thereafter with results being reported to QAPI monthly.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		2/8/24

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

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K 923	Continued From page 6 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 923	K923	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING **02 - 1771 EAGLEVIEW CIRCLE** B. WING _____	**01/11/2024**

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

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K 923	Continued From page 7 facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by observation in the Basement that the Med Gas (O2) Storage Room was found unsecured. 2. On 01/11/2024 between 10:00 AM and 2:30 PM, it was revealed by observation in the Basement that the Med Gas (O2) Storage Room that a cylinder was found freestanding and unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	St. John's has and always will ensure that oxygen cylinder and container storage is secured and has safe holding containers for them. Oxygen room door has had keypad lock placed on it on 2/8/2024. Oxygen room racks were placed by NW respiratory representative on 1/15/2024. EVS Director or designee will check oxygen room door lock and appropriate cylinder storge racks 1x daily (M-F) for 4 weeks, 1x weekly for 4 weeks, and 1x monthly for 1 month. Results will be reported to QAPI.	