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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MYP1

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00045

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/03/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 75 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 01/11/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/11/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**11/29/2021**
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 11, 2022

CMS Certification Number (CCN): 245407

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

Dear Administrator:

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

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

Effective December 8, 2021 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 11, 2022

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

RE: CCN: 245407
Cycle Start Date: September 24, 2021

Dear Administrator:

On October 20, 2021, we notified you a remedy was imposed. On December 3, 2021 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 December 8, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 4, 2021 be discontinued as of December 8, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 20, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 24, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L2) **346740600**

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(L3) **ST JOHN LUTHERAN HOME**
(L4) **201 SOUTH COUNTY ROAD 5**
(L5) **SPRINGFIELD, MN** (L6) **56087**

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| | |
|---|---|
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| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
| **8. Full Survey After Complaint** | |

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/24/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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From (a) :
To (b) :

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___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 75 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Alisha Jordan, HFE NE II 11/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/29/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :

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**11/01/1988**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
October 20, 2021

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

RE: CCN: 245407
Cycle Start Date: September 24, 2021

Dear Administrator:

On September 24, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On September 24, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## 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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 4, 2021.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 4, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also

notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 4, 2021, (42 CFR 488.417 (b)).

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.

## SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St John Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 24, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient

practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 24, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and

488.456.

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 DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal

Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245407 | A. BUILDING _____ B. WING _____ | C 09/24/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 9/20/21 to 9/24/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 035 SS=C | LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8)<br><br>§483.73(c)(8); §483.475(c)(8)<br><br>*[For LTC Facilities at §483.73(c):]<br>[(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]<br><br>*[For ICF/IIDs at §483.475(c):]<br>[(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] | E 035 | | 10/25/21 |

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

Electronically Signed | 10/29/2021

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245407 | A. BUILDING _____ B. WING _____ | C 09/24/2021 |

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

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|---|---|---|---|---|
| E 035 | Continued From page 1<br><br>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure their emergency preparedness plan included a method for sharing information the facility had determined appropriate, with residents and their families or representatives. This had the potential to affect all 60 residents currently residing in the facility and their families/representatives.<br><br>Findings include:<br><br>During review of the facility's emergency preparedness plan (EPP), undated, there was no indication the facility had shared any EPP information with clients and their families or representatives.<br><br>When interviewed on 9/23/21, at approximately 10:30 a.m. registered nurse (RN)-A, inservice coordinator responsible for emergency preparedness confirmed information related to the EPP had not been shared with residents and their families or representatives. | E 035 | The Emergency Preparedness Communication Plan letter was sent to current residents and resident representatives on 9/27/21. This letter was also inserted into the admission packets and added onto the acknowledgement form.<br>Emergency Preparedness Communication plan policy developed.<br>Safety Committee will review annually or sooner if need arises.<br>Safety Director/designee will monitor overall compliance. | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)<br><br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the | E 041 | | 12/1/21 |

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| E 041 | Continued From page 2<br>policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. | E 041 | | |

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| E 041 | Continued From page 3<br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012. | E 041 | | |

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| E 041 | Continued From page 4<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to implement emergency and standby power systems in compliance with Life Safety Code ( 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, (NFPA 70) ), this has the potential to affect all 60 residents residing in the facility, staff, and visitors.<br><br>Findings Include:<br><br>See K0918<br><br>During a facility tour between 1:30 p.m. and 4:30 p.m. on 9/23/21, observations, staff interview, and documentation reviewed revealed the following:<br><br>During the walk-through inspection of the facility and review of documentation, the install date of the facility's emergency generator battery was greater than 7 years prior.<br><br>During walk-through inspection, the facility lacked an emergency shut off outside of the room in which the generator is housed.<br><br>These deficient practices were confirmed by the Facility Maintenance Director at the time of discovery on 9/23/21. | E 041 | 1. Emergency Power. Battery paperwork showed most recent replacement of 2014, which is outside of manufacturer□s recommendation.<br>-Battery was not marked.<br>-Paperwork located: Battery was replaced 1-6-2021.<br>-Information sent to Fire Marshal<br>-Maintenance Director will monitor<br>-Completed 10/25/2021<br>2. Remote Manual stop station for generator was not located<br>-Electrical contractor called 10/22/2021<br>-Emergency switch ordered.<br>-Maintenance Director will monitor.<br>-Completion date: 12-1-2021 | |
| F 000 | INITIAL COMMENTS | F 000 | | |

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| F 000 | Continued From page 5 | F 000 | | |

On 9/20/21 to 9/24/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The survey resulted in an Immediate Jeopardy (IJ) at F689 when R4 was identified with cigarette burns to his clothing and wheelchair from unsupervised smoking. The IJ began on 9/23/21, at 1:52 p.m. and the immediacy was removed on 9/24/21, at 11:10 a.m..

In addition, an extended survey was completed on 9/24/21, related to the substandard quality of care findings.

The following complaints were found to be SUBSTANTIATED H5407031C (MN67003) however NO deficiencies were cited due to actions implemented by the facility prior to survey:

The following complaints were found to be UNSUBSTANTIATED: H5407028C (MN76129), H5407029C (MN76268), H5407030C (MN72089), and H5407032C (MN75733).

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 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

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| F 000 | Continued From page 6<br>regulations has been attained. | F 000 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§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<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide services to maintain and prevent loss of range of motion (ROM) for 1 of 3 residents (R18) reviewed for limited ROM.<br><br>Findings include:<br><br>R18's diagnosis (found in the medical record on the physician order sheet) dated 91/21, included: Alzheimer's disease (a disease that destroys memory), muscle weakness, and dysphagia (language disorder). | F 688 | R18 care plan updated. Orders for OT obtained for R18 on 10/25/21. All residents will be reassessed for range of motion and ROM interventions/documentation. Therapy will assist. Referrals to OT as needed. Current range of motion charting is on paper. Will implement range of motion and exercise charting via electronic record. Updated Joint Mobility Assessment form. Reviewed and updated ROM Policy and Resident Mobility and ROM policy.<br>Staff education of ROM, ROM procedure, | 11/26/21 |

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| F 688 | Continued From page 7<br>R18's quarterly minimum data set (MDS) assessment dated 7/4/21, identified R18 required extensive assistance with activities of daily living (ADL's). The MDS indicated R18 had functional limitation in range of motion of both upper and lower extremities. Previous quarterly MDS assessments dated 4/4/21 and 1/3/21, identified same range of motion impairment.<br><br>R18's occupational therapy (OT) discharge progress note and instructions dated 10/18/19, indicated R18 was evaluated for hand ROM and positioning. The OT note further indicated staff will be trained and implement exercises to hands to prevent breakdown and contractures, as well as wheelchair positioning and transfer. The progress note indicated there was little tightness/contractures at the time of the evaluation (physician was made aware that hand contractures were occurring) continue to monitor and adjust as needed. R18 had not been assessed since this time.<br><br>R18's current physicians order dated 9/1/21, identified an order dated 10/22/20, for ROM exercises recommended by OT (10 repetitions for each exercise to arms twice daily). Order did not address the hands.<br><br>R18's care plan dated 7/13/21, identified R18 as having alternation in self care, related to Alzheimer's disease and arthritic changes. R18 requires extensive assistance with all ADL's. The care plan identified R18 as having alteration in mobility, related to Alzheimer's disease, severe loss of ROM and arthritic changes. The care plan indicated R18 will hold hands in a fist frequently. The care plan lacked interventions for identified impairment in hands. In addition the care plan did | F 688 | documentation, reporting any changes in range of motion and therapy screening forms.<br>Joint Mobility Assessment will be reviewed quarterly at care conference with resident representative and IDT. Audits of rom charting will be completed weekly x 3months and reviewed at IDT meetings. QAPI Committee will review and make further recommendations. QA&A to review at next meeting on 1/27/22. DON/designee will monitor overall compliance. | |

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| F 688 | Continued From page 8 | F 688 | | |

not identity upper extremities ROM per physicians orders.

R18's ROM log for the past 3 months (June 2021-August 2021) included ROM to the upper extremities daily, but did not include the hands. The log indicated ROM to the upper extremities had not been done during these months. The log also directed staff to implement ROM once daily, when the physicians orders indicated twice daily.

Observation on 9/20/21, at 5:05 p.m. R18 was observed to have her right hand clenched tightly. When asked R18 if she was able to open her hand, she independently made attempts, but was unable. R18 was unable to express if she had pain in her hand, due to decreased cognition.

During observation and interview on 9/21/21, at 2:28 p.m. R18 was sitting in a recliner in her room. R18 continued to clench her right hand tightly and also had her left hand completely closed. R18's husband was visiting. R18's husband indicated R18 has clenched her right hand for the past year. R18's husband was not aware of any type of splint or range of motion (ROM) to the right hand. R18's husband attempted to open R18's right hand. The right hand would open only partially with manual assistance. .R18's husband stated he was concerned about the impairment in the right hand ,but there had not been any discussions regarding preventative treatment

Interview on 9/21/21, at 1:40 p.m. trained medication assistant (TMA)-A indicated the NA's provide ROM daily with morning cares and at bedtime. TMA-A indicated the ROM log directs staff on what type of ROM needs to be done as

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| F 688 | Continued From page 9 | F 688 | | |

well as how often. TMA-A confirmed R18's ROM did not include the hands and ROM to the upper extremities had not bee implemented, in the past 3 months. TMA-A indicated R18 has clenched her right and left hand for the past year, and confirmed R18 had not been re-assessed by OT since 10/18/19.

Interview on 9/23/21, at 9:45 a.m. nursing assistant (NA)-H indicated R18's right hand has been clenched tightly for several months. NA-H indicated R18 will clench the right hand so tight that her fingernails will dig into the skin. NA-H confirmed R18 had not had ROM done in the past 3 months, and has had no splint/protective device to the right hand, to prevent contractures and decreased ROM.

Interview on 9/23/21, at 9:50 a.m. registered nurse (RN)-B confirmed R18's ROM had not been assessed since R18 was last evaluated, by OT on 10/18/19. RN-B further confirmed the ROM log for R18 indicated ROM to R18's upper extremities, had not been done in the past 3 months.

Review of the facility policy Resident Mobility and Range of Motion, revised 9/19, indicated residents will not experience avoidable reduction in ROM and residents with limited ROM will receive treatment and services to increase or prevent further decrease in ROM. As part of the resident's comprehensive assessment , the nurse will identify the residents current ROM, identify conditions that place the resident art risk, and underlying factors, the care plan will be developed that include interventions (may include therapy services) and documentation of the residents progress or any changes or decline in

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| F 688 | Continued From page 10<br>the residents condition and needs | F 688 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety with smoking for 1 of 1 resident (R4) identified to have cigarette burns on clothing and wheelchair. This resulted in an immediate jeopardy (IJ) situation, substandard quality of care, for R4 who remained at risk for burns and serious injury with unsupervised smoking.<br><br>The IJ began on 9/23/21, when it was identified R4 had sustained incidents of cigarette burns to his clothing and wheelchair from unsupervised smoking. On 9/23/21, at 1:52 p.m., the director of nursing (DON), administrator, and social worker (SW) were notified of the IJ for R4. The IJ was removed on 9/24/21, at 11:10 a.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D).<br><br>Findings include: | F 689 | Facility reassessed r4 smoking practice on 9/23/21. Evaluation of smoking determined he was able to smoke safely with donning of smoking apron to catch any potential ash. R4 smoking articles including apron, lighter and cigarettes will be kept at the nurses station medication room so staff can ensure compliance and that he has smoking apron on. Resident is given one cigarette at a time to ensure his compliance. R$ given new wheelchair and wheelchair is monitored daily for burn holes. Care plan was updated to reflect these changes.<br>Social worker and Director of Nursing reassessed the other two residents that smoke which included inspecting clothing and electric wheelchairs for burn holes. Smoking care plans were reviewed and updated.<br>Smoking policy and procedure was reviewed and revised. All facility staff were educated on 9/23/21 & 9/24/21 on smoking policy which included to report | 10/28/21 |

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| F 689 | Continued From page 11<br>R4's annual Minimum Data Set (MDS) assessment dated 9/19/21, identified moderately impaired cognition, moderately impaired vision, and did not display any episodes of rejection of care. R4's medical diagnoses included chronic lung disease and heart failure. R4 required extensive assistance with activities of daily living (ADLs), used a walker and wheelchair as mobility devices, and currently used tobacco products.<br><br>R4's Medical Diagnosis listing printed 9/23/21, identified R4 had difficulty in walking, muscle weakness, abnormalities of gait and mobility, and repeated falls.<br><br>On 9/20/21, at 4:16 p.m. R4 was observed seated in his wheelchair with cigarettes and lighter in shirt front pocket and 3 lighters on a TV stand in his room. R4 stated he keeps his cigarettes and lighter on himself and goes outside whenever he wants to smoke, and does not wear an apron. R4's plaid shirt had eraser size holes on the bottom of shirt; the holes edges were charred and brown/black in color. When asked, R4 stated when it was windy the ashes from his cigarette might blow on his clothes.<br><br>On 9/21/21, at 12:40 p.m. R4 was observed wheeling himself out of his room in a wheelchair, down the hallway, exited the facility doors and remained directly outside the glass doors of the facility. R4 removed an opened package of cigarettes from the side pocket of his green jacket, removed a cigarette and standard lighter. R4 picked up the cigarette using his thumb and pointer finger and placed it into his mouth, R4 then used his hand to hold the cigarette with his thumb and first finger and used his opposite hand to hold the lighter. R4 lit the cigarette and used | F 689 | any cigarette burns to the charge nurse who will then report to social service and director of nursing. Smoking assessment will be completed with any report of burns. Audits of residents compliance with smoking policy will be completed monthly x3 months. QAPI Committee will review and make further recommendations. QA&A will review at next meeting on 1/27/22.<br>Social Service Director/designee will monitor overall compliance. | |

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his left hand to bring it to his mouth. R4 finished the cigarette at 12:48 p.m. and tossed the remaining filter and butt into the cigarette receptacle by the facility doors. R4 lit another cigarette and finished smoking at 12:55 p.m. He tossed the remaining filter and butt into the cigarette receptacle by the facility doors, re-entered the facility and proceeded to his room.

On 9/21/21, at 1:00 p.m. R4 stated none of the staff had spoken to him about his smoking, nor do they come outside with him while he smokes. When questioned, he stated he was not offered a smoking apron. R4's jacket was observed to have multiple holes through the jacket. The holes were burnt through the jacket and had brown/black edges. R4 confirmed the holes were most likely from ashes from his cigarette. R4 stated he smoked several times a day always going outside on his own to smoke. R4 stated the wind caused the ashes to fly and land on his shirt, pants, and jacket. R4 stated he had never sustained burns. In addition, R4 stated some of the holes were in his clothing prior to coming to the facility.

An electronic progress note written by LPN-B dated 6/10/21, at 12:26 a.m. indicated at 0020 [12:20 a.m.] an aide reported resident had a burn hole in his gray sweat pants an approximate 2.5 cm burn hole was in the upper right thigh area, burned edges were brown in color. Will pass off on report to monitor resident, resident will need a skin check to rule out an injury to cigarette burns to upper right thigh and hands. The progress note did not identify if the burn hole occurred prior to the residents admission to the faility.

An electronic progress note dated 6/10/21, at

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7:55 a.m. RN- B identified a skin check was completed on R4 with his bath, no bruises, skin tears or pressure areas noted, no sign of burn on leg. No edema noted in extremities will continue with current plan of care.

An electronic progress note dated 6/10/21, at 10:41 a.m. SW identified R4 was reassessed for smoking and went over the smoking policy and guidelines and provided resident re-education, resident was able to demonstrate safe and independent smoking. "continues to be safe to smoke his cigarettes independently and hold them and the lighter at all times." The note lacked any observation, assessment or dictation to describe how the determination had been made of R4's unsupervised smoking abilities and even though R4 had several new burn holes identified on his clothing, on 6/10/21.

R4's smoking evaluation dated 6/10/21, identified "talked to resident about potentially wearing a smoking apron-resident is adamantly refusing to wear a smoking apron. Concerns of burn hole in his jacket-resident denied." The smoking evaluation lacked assessment information related to burn holes on clothing or wheelchair and interventions to provide safety while R4 smoked.

R4's most recent Smoking Safety Evaluation dated 9/12/21, identified R4 currently used tobacco, independent to smoke, and refused to wear smoking apron (handwrote in the comments). The assessment did not identify R4's concerns related to burn holes in clothing or wheelchair, or any information on how the burn holes and refusal of smoking apron would be addressed. R4 displayed no physical limitations which would interfere with their ability to get

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outside or back in the facility. The assessment listed a section labeled, "Resident smokes safely" and "Resident utilizes ashtray safely and properly," which identified R4 did not burn furniture, clothing, skin self or others, gets ashes into ashtray, does not cause/allow sparks or lit tobacco to fall anywhere but into the ashtray. The evaluation included a section with choices that included: "resident has demonstrated ability to safely smoke without supervision", "resident exhibits poor safety awareness when smoking, and a care plan must be in place to promote smoking safety", "resident must wear smoking apron at all times", "resident requires staff assistance to hold smoking material." The option for, "resident has demonstrated ability to safely smoke without supervision", was checked and no other options were checked.

R4's care plan printed 9/22/21, identified R4 was an active smoker, assessed to be a safe independent smoker, strengths: alert and orientated and interventions included: will smoke in designated areas. smoking assessment completed per policy, at least quarterly.

On 9/21/21, at 2:34 p.m. an interview with social worker (SW) stated she completed R4's smoking evaluations quarterly. SW stated R4 smoking evaluation included an observation while he smoked, and she stated no concerns and deemed him safe to smoke independently. SW stated R4 was offered a smoking apron, as she offered to all residents, and he refused. SW stated she was not aware of the burn holes on his jacket or his clothing, and further stated if she was aware of clothing burn holes, he would need to wear an apron to keep his privileges to smoke. SW stated R4 has had no accidents with

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smoking.

On 9/21/21, at 2:47 p.m. an interview with registered nurse (RN)-B and nursing assistant (NA)-A stated R4 was independent with his smoking and staff did not help him, nor did R4 wear or use any adaptive devices while he smoked. RN-B and NA-A stated they have offered R4 a smoking apron in the past and he refused, and family were aware. RN-B and NA-A stated approximately six months ago burn holes in R4's wheelchair and clothing were noticed. NA-A stated she was not sure if the burns in the clothing were old or new burn holes though as he came to the facility with the clothing. NA-A confirmed R4 did not come to the facility with his current wheelchair. NA-A stated the burns in the wheelchair would have been since R4 arrived at the facility. Further, RN-B and NA-A stated they had reported these burns to the nurse(s), however, was unable to recall anyone specific it had been reported to.

On 9/22/21, at 10:17 a.m. an interview with the DON stated the SW does an assessment with smoking residents and determines if the residents were safe to smoke. The DON stated R4 smokes, "a lot" and stated approximately three months a NA reported a burn hole in R4's jacket, the DON was unable to recall the specific person who reported it. The DON stated the SW was notified and SW reassessed R4 and determined he was safe to smoke. The DON stated she did not document the incident. The DON stated she expected residents with clothing burn holes from smoking would be offered a smoking apron. The DON was unaware if R4 was offered a smoking apron as it was the responsibility of the SW. The DON stated she was not aware of R4 wheelchair

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burn holes. The DON confirmed burn holes in a wheelchair and/or clothing were a safety issues and stated she would expect the burn holes and smoking safety would be discussed in Interdisciplinary Team (IDT) meetings and care conferences. The DON discussed the facility policy was residents needed to be deemed independent to smoke as the facility does not provide supervision when residents smoke. The DON stated the facility was ultimately responsible to ensure R4 was safe. DON stated information related to R4's smoking were done as in passing conversations and not documented.

On 9/22/21, at 10:31 a.m. an interview with RN-C stated she is the MDS coordinator and had not completed any smoking assessments with R4. RN-C stated she participated in R4 care conferences and stated in the past concerns were brought about R4's cognition. RN-C further indicated R4's burn holes on his wheelchair were brought up in either a care conference or IDT and was discussed that R4 should wear a smoking apron and stated she was not sure of the outcome of the concerns. RN-C stated she was not aware if the SW knew about R4 wheelchair burn holes. RN-C stated staff made her aware of the burn holes, but she did not see them and was unable to recall the specific staff who talked about R4's burn holes.

On 9/22/21, at 10:54 a.m. and interview with RN-A stated she heard about burn holes in R4's pants from a NA on the day shift and was unable to recall the specific staff. RN-A stated staff were to monitor R4 for more smoking concerns, and stated she was unaware who was to monitor R4. RN-A stated the SW would be responsible for following up with smoking concerns.

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On 9/22/21, at 11:15 a.m. an interview with the SW stated within the last two months, she was made aware of R4's burn holes in his jacket and she reassessed R4 smoking and observed no safety concerns. R4 was offered a smoking apron and refused. SW indicated she was aware of the clothing burn holes and should have considered the burn holes as part of the assessment and verified she did not assess the wheelchair for burn holes.

On 9/22/21, at 5:07 p.m. an interview with NA-D stated she had observed R4 outside smoking and would see him through the facility window. NA-D stated in the past she assisted R4 outside to smoke because it was the time of day the doors were locked. NA-D stated she had never seen the ashes fall on him. NA-D stated she had observed holes on R4's clothing and wheelchair and stated she had told a nurse about the holes a few months ago, and stated she was not able to remember the nurse's name. NA-D stated the holes on the wheelchair were from burn holes when R4 smokes but stated she did not witness the burns to the wheelchair occur. Further, NA-D stated R4 was independent with using his cigarettes and lighter,

On 9/22/21, at 5:12 p.m. interview with trained medical assistant (TMA)-A stated she has observed R4 going outside to smoke but was not outside when he smokes and stated she has not closely watched him smoke. TMA-A stated about two months ago she saw a burn mark on his wheelchair and was not able to recall if she reported the burn.

On 9/23/21, at 7:44 a.m. an interview with family

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member (FM)-A stated she was aware of the burn holes in R4's clothing and wheelchair. FM-A stated the burn holes in the wheelchair were not there prior to the resident admitted at the facility. FM-A stated R4 brought his clothes from home, so there could have been from holes in his clothes prior. FM-A stated someone from the facility had called in the past and stated R4 would be monitored more related to smoking, however FM-A could not remember more specific details.

On 9/23/21, at 11:00 a.m. R4's wheelchair seat was observed with SW and confirmed an approximate 6-inch area, on the seat of the wheelchair, had multiple burn holes in varying depths on the vinyl which exposed the inner lining of the wheelchair seat. The holes had black and brown charred edges. SW further stated she suspected burn holes were related to R4's smoking.

Further, the medical record lacked any reaassement of R4's unsupervised smoking abilities or recorded incident report(s) related to the cigarette burns sustained on his clothing and wheelchair, nor any evidence the facility had attempted to provide on-going collaboration with R4 to develop and implement interventions or therapies to promote safety related to his unsupervised smoking to keep him safe. The facility provided no additional notes or medical record entries regarding these items during the survey.

Although the facility was aware R4 had multiple burn holes on his clothing and wheelchair, they had not included this as part of the assessment or determined how these burns hole occurred. The facility had not provided on-going

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collaboration with R4 to develop and implement interventions to keep him safe while smoking.

Policy titled Resident Smoking Policy dated 12/2017, indicated:

Policy: St John Lutheran Home has Established a safe smoking policy for residents. Residents that smoke can be admitted to the facility but must adhere to the policy and procedure of Saint John Lutheran home, as well as being evaluated to be safe and independent and smoking. The facility does not encourage or promote smoking but allows for individual choice by residents deemed to be safe and smoking.

Policy interpretation and implementation
1. Prior to and upon admission resident shall be informed of the facility smoking policy, and the extent to which the facility can accommodate their smoking or non-smoking preferences by social services.
2. Residents that wish to smoke and who are evaluated as "independent" with smoking will be allowed to smoke in dependently
4. Metal containers, with self-closing covers, are readily available in smoking areas.
6. The resident will have a Smoking Evaluation conducted on admission to determine if he or she is a safe smoker. The Smoking Evaluation will be maintained in a medical record of the resident. if a smoker, the evaluation will include: d. Ability to smoke safely without supervision (per a completed Safe Smoking Evaluation) A smoking apron will be provided by the facility if determined required by the smoking evaluation. e. Residents must be evaluated as "independent" with smoking. The results of the smoking evaluation will be included in the resident care plan. Any

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resident evaluated as "NOT" independent with smoking will not be allowed to smoke according to facility policy.
7. A resident's ability to smoke safely will be reevaluated upon re admission, quarterly, upon significant change (physical or cognitive), annually and as determined by staff.
a. if at any time of evaluation, the resident is "NOT" independent or smoking or ceases to be "independent "with smoking they will no longer have smoking privileges. A care plan for smoking cessation will be created by social services.
9. The facility may impose smoking restrictions on a resident at any time if it's determined the resident cannot smoke safely.
11. Resident smoking articles [cigarettes; E cigarettes; lighters; matches; smoking apron] are permitted to keep in their possession. Only the smoke disposable safety lighters are permitted. All other forms of lighters including matches are prohibited
13. This facility maintains their right to confiscate smoking articles found in violation of our smoking policies. Confiscated resident smoking materials will be documented. A meeting with the resident or representative and SW according regarding the circumstances that led to the confiscation will be held.

The policy lacked any direction or procedure for staff to implement on how to address cigarette burn(s) on clothing and/or skin, should they occur.

No further policies or procedures related to smoking safety or unsupervised smoking were provided.

The IJ which began on 9/23/21 at 1:52 p.m., was

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removed on 9/24/21, at 11:10 a.m. after the facility successfully implemented a removal plan which included the following:

- R4 was reassessed for smoking practices and observed prior burn holes in pants and multiple burn holes on the seat of his wheelchair. R4 can hold cigarette correctly, able to light cigarette safely with lighter, disposed ash in receptacle correctly and is able to extinguish his cigarette safely when finished in receptacle. Evaluation of smoking determined he was able to smoke safely with the donning of a smoking apron to catch any potential ash that would land on his lap. R4 smoking articles included apron, lighter and cigarettes and will be kept locked up at the 1sw nurses station medication room so staff can ensure R4 wears his smoking apron on. R4 will be given one cigarette at a time to ensure his compliance. R4 was given new wheelchair and the wheelchair will be monitored for burn holes.
- On 9/23/21 and 9/24/21, nursing staff on station 1sw and TR staff educated on R4's smoking assessment, care plan and requirement to wear smoking apron and those smoking articles are to be kept at desk. If R4 refuses to wear apron, then forfeits his smoking privileges.
- On 9/23/21 and 9/24/21, staff in all departments educated on Smoking Policy which was revised to include all staff to report any cigarette burns to charge nurse who will then report to social service and director of nursing. Removal plan information has been posted for all departments. Staff Development will track that all staff have been educated on the removal plan. Smoking reassessment will be completed with any report of burns.

Smoking policy and procedure reviewed, and changes made on 9/23/21.

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-R4's care plan was updated to include smoking assessment, keeping cigarettes at 1sw nurses' station, one cigarette given at a time and apron usage. Family updated and has no concerns with his safety when smoking.

On 9/24/21, from 10:11 a.m.-11:08 a.m. all working staff were interviewed to ensure the updated smoking policy was read and understood, and direct care staff education had been provided related to R4 required smoking apron at all times when smoking, staff to report any burn holes or safety issues with smoking to charge nurse, smoking articles included smoking protector, cigarettes and lighter to kept as nurses station, staff to give resident once cigarette at a time to ensure his compliance with smoking apron, and included ensuring R4's wheelchair and clothing were routinely monitored for potential burn injuries and R4 used a smoking apron.

Care plan printed 9/24/21, indicated R4 required smoking apron at all times when smoking, staff to report any burn holes or safety issues with smoking to charge nurse who then notify social services and DON, involve family with compliance or concerns, smoking articles included smoking protector, cigarettes and lighter to kept as nurses station, staff to give resident once cigarette at a time to ensure his compliance with smoking apron, if resident refuses to return light, reapproach at a late time family intervention as need, social service intervention as need, chaplain intervention as needed

The updated policy titled Resident Smoking Policy dated 9/23/21, included the addition: Staff are to report any burn holes in clothing or other safety concerns with smoking to charge nurse

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| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit) and 2 of 2 residents (R29 & R49) refrigerated controlled medications, to prevent potential loss or | F 761 | Eye drops were labeled with date and checked for expiration. Insulin pen had been opened the day prior. Label with date open applied. Staff reconciled Ativan in fridge in narcotic book. Expired eye drops destroyed. Refrigerator Ekit tag | 11/26/21 |

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| F 761 | Continued From page 24<br>diversion. In addition failed to date eye drops and insulin when opened. In addition, the facility facility failed to secure medication storage for 1 of 2 medication storage rooms. This had the potential to affect all 58 residents residing in the facility who may require controlled substances, eye drops and insulin.<br><br>Findings include:<br><br>On 9/23/21, at 9:45 a.m. a tour of the 2nd floor medication storage room was conducted with trained medication assistant (TMA)-A and registered nurse (RN)-B. Prior to the tour, the door to the medication room was observed to be unlocked and opened. There were no licensed staff in the area. TMA-A was informed by the surveyor, the door had been open. TMA-A verified it should be locked at all times, and was unsure why it was left open. Located within the medication room was an unlocked refrigerator that contained two 30 ml vials of injectable lorazepam (an anti-anxiety medication/controlled substance) for R29 and R49. The lorazepam was stored on the rack of the refrigerator. RN-B indicated the facility practice was to store refrigerated controlled substances/narcotics in unlocked refrigerator on the shelf. RN-B also indicated lorazepam is not routinely reconciled if it is given as needed (PRN) to a resident. Review of the reconciliation of lorazepam for R29 indicated the medication was ordered PRN and had not routinely been reconciled. Observation of the medication stock supply stored in a cupboard in the medication storage room, reveled 1 bottle (30 tablets) of expired aspirin 325 mg. Expiration date was 8/21.<br><br>During observation on 9/23/21, at 11:15 a.m. the | F 761 | reconciliation was corrected on 9/24/21.<br>Audit of the med room and med carts completed on 10/27/21 to ensure all eye drops dated, insulin pens dated and to check for expired medications.<br>Developed policies for medication storage, administration of meds, controlled medication storage and emergency pharmacy service and emergency kits. Licensed nurses and trained medication aides will be educated on new policies and re-educated on dating of bottles/meds and reconciliation of controlled meds by 11/19/21.<br>Ongoing audits of dating meds, expired medications and reconciliation will be completed monthly x 3 months then every other month x 3. Random audits will be completed to ensure med rooms are locked 4x weekly x 4 weeks then 2x weekly x 4 weeks then weekly x 4 weeks.<br>QAPI Committee will monitor and make further recommendations. QA&A will review at next meeting on 1/27/22.<br>Director of Nursing/designee will monitor overall compliance. | |

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| F 761 | Continued From page 25 | F 761 | | |

2nd floor medication storage cart, included a Novolog Flexpen insulin pen for R7 not dated when opened. A bottle of Latanoprost eye solution (2.5 ml) for R32 had an open date of 8/7/21 (expires 45 days after opening). The Latanoprost also expired on 9/21/21 and staff continued to use as of 9/23/21. Interview with RN-B and TMA-A confirmed the above findings. RN-B stated all staff are responsible for dating eye drops and insulin when opened, and the facility pharmacist will check the storage carts periodically for expiration dates and labels when opened, and had just checked the cart that day.

During observation on 9/23/21, at 11:30 a.m. a tour of the 1st floor medication storage room was conducted with RN-D. Located within the medication room was an unlocked refrigerator that contained a tackle box, which was identified by RN-D as the facility's E-Kit. The E-Kit was observed to contain one vial (30 ml) of injectable lorazepam (an anti-anxiety medication/controlled substance). The E-kit was secured with a numbered plastic pull tag attached to the clasp of the box. RN-D indicated the lorazepam is not reconciled routinely, only when it is given. The E-Kit also contained replaceable number tags. RN-D stated the extra tags were replacements when opening the E-Kit. RN-D confirmed the current tag could be removed and replaced with another tag, without staff knowledge. RN-D confirmed the tags were not monitored/reconciled on a routine basis. RN-D also confirmed the E-Kit/refrigerator did not have a secured lock on it and there was no system in place to monitor the E-Kit.

During observation on 9/23/21, at 11:45 a.m. of the medication storage cart on the 1st floor,

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| F 761 | Continued From page 26<br>included a bottle of Latanoprost eye drops for R107 not dated when opened. A bottle of natural tears solution (15 ml) for R52 that was not dated when opened , and a tube of Systane eye gel for R2 that was not dated when opened..<br><br>Interview on 9/23/21, at 1:00 p.m., the director of nursing (DON) stated she expected the licensed staff to routinely monitor the E-Kit contents, and to ensure the lorazepam was stored in a secure place. The DON also indicated the staff had training on labeling eye drops and insulin when opening and monitoring the expiration dates.<br><br>Review of the facility policy Administration of Drugs from the Emergency Box dated 4/04, indicated when removing items from the E-Kit and breaking the numbered tag, the tag should be replaced. The number of the tag will be entered on the log sheet in the ER medication record book. The assistant director of nursing (DON) or assigned designee will check the tag once a day to assure it is in place.<br><br>A policy was requested for security of the medication room, security of controlled substances/narcotics as well as labeling eye drops and insulin when opened. The facility did not provide the requested policies. | F 761 | | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs<br>CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility- | F 790 | | 11/25/21 |

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| F 790 | Continued From page 27<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to assess dental needs and ensure dental services were provided for 1 of 1 resident (R22) who had dental concerns. | F 790 | Dental reassessment completed on 9-22-21 for R22. Dental appointment scheduled with local dental clinic per guardian request.<br>Audits will be completed of all residents | |

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| F 790 | Continued From page 28<br>Findings include:<br><br>R22's admission Minimum Data Set (MDS) assessment dated 4/15/21, identified R22 as understanding and being understood. No problems with speech. The MDS identified R22 as requiring extensive assistance with personal cares, that included oral cares. The MDS identified R22 as not having any natural teeth/oral problems.<br><br>R22's quarterly MDS assessment dated 7/11/21, identified R22 as requiring extensive assistance with personal cares, that included oral cares. The MDS identified R22 as having no oral concerns.<br><br>During observation and interview on 9/21/21, at 9:37 a.m., R22 stated he had a couple decayed teeth that needed to be removed. R22 indicated he told the staff months ago that he would like to see a dentist, but that had not been done. The resident was noted to have a chipped front tooth with all other teeth intact. R22 stated he currently did not have any pain.<br><br>During observation and interview on 9/21/21, at 12:27 p.m., R22 continued to complain about wanting to see a dentist for some decayed teeth. R22 indicated he could not recall when he told staff or who he told. R22 indicated prior to admission he had seen a dentist, who told him he had a couple of teeth that were decayed and needed extracting. R22 was observed to have all of his own teeth, with noted discolored and dark in color molars ( flat teeth located at the back of the mouth).<br><br>R22's admission assessment dated 4/12/21, identified R22 as having upper and lower | F 790 | regarding dental care. Residents who have not been to dentist in past year, facility will notify resident representative to determine resident dental needs.<br>Reviewed dental services policy. At every care conference dental service needs will be discussed and documented. Facility is on list for mobile dental care starting in 2022.<br>Education will be provided at staff meeting on 11/9/21 and 11/10/21.<br>Audits of care conference summaries will be completed monthly x3months to ensure compliance. QAPI Committee will review and make further recommendations. QA&A Committee will review at next meeting on 1/27/22.<br>DON/designee will monitor overall compliance. | |

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| F 790 | Continued From page 29 | F 790 | | |

dentures.

R22's dental record assessment dated 4/15/21, indicated R22's oral cavity was pink with no sores. R22 has upper and lower full dentures and has no concerns with his dentures. A follow up assessment dated 7/7/21, indicated R22 continued to not have any concerns with his dentures

R22's nutritional assessment dated 4/8/21 identified R22 as having upper and lower dentures and has no concerns/problems with chewing food.

R22's current care plan dated 9/22/21, identified R22 as having full upper and lower dentures and requiring extensive assistance with personal cares.

Review of the NA care sheet for R22, did not include oral cares.

Interview on 9/22/21, at 9:30 a.m., the facility MDS coordinator indicated she could not recall if she had completed R22's dental assessment or if she had just signed it off for another nurse. The MDS coordinator could not recall examining R22's oral cavity, even though she had completed the MDS. The MDS coordinator stated dental concerns and appointments are usually discussed at care conference, but she could not recall if R22 had any dental concerns.

R22's care conference meeting note dated 7/20/21, did not address R22's dental needs or if they had been discussed.

Interview on 9/22/21, at 9:45 a.m. registered

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| F 790 | Continued From page 30<br>nurse (RN)-E confirmed she had completed R22's admission assessment on 4/8/21. RN-E indicated R22 was confused that day and she may not have gotten a good observation of his oral cavity, and assumed he had dentures<br><br>Interview on 9/21/21, at 3:00 p.m. nursing assistant (NA)-E and NA-F indicated they were both aware of R22 having his own teeth. NA-E stated staff will set up the oral care supplies, and with encouragement R22 will brush his own teeth. NA-E and NA-F further stated R22 has expressed concerns about having decayed teeth and seeing a dentist, and thought the charge nurses were aware.<br><br>Review of a facility policy Dental Examination/Assessment dated 1/04, indicated each resident shall undergo a dental assessment prior to or within ninety days of admission or per residents discretion. This assessment includes: the resident shall be offered dental services as needed, dental examinations will be made by the residents personal dentist or as directed by the resident, records of dental care shall be made a part of the residents medical record and upon conducting a dental examination and a resident needing dental services will be promptly referred to a dentist. | F 790 | | |
| F 806 SS=E | Resident Allergies, Preferences, Substitutes<br>CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; | F 806 | | 11/25/21 |

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| F 806 | Continued From page 31<br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility ensure that individual food preferences/ food choices were honored for 8 of 8 residents (R29, R13, R5, R53, R42, R34, R55, R25) reviewed for food preferences.<br><br>Findings include:<br><br>During an interview on 9/20/21, at 4:26 p.m., R29 stated, they give you a menu - pointing to a menu taped on the wall next to his recliner, adding no one asked him what he wanted. "You get what you get and if don't like it you're out of luck...I would like more choices of what there is to eat."<br><br>During an interview on 9/21/21, at 2:32 p.m., trained medication aide (TMA)-B and licensed practical nurse (LPN)-A both stated residents used to get a menu every week in order to select their food, but they don't get that anymore. LPN-A stated, "They get served whatever is on the menu for that meal, and if they don't like it, they can ask for something different." LPN-A confirmed that a resident could ask for something different, but it would be after their meal had already been served to them in the dining room or their room.<br><br>During a resident council meeting on 9/22/21, at 11:00 a.m., the following residents were in attendance: R13, R5, R53, R42, R34, R55, and R25. Residents were asked about food choices at meal times. R53 stated, "We get a menu for a month; there isn't a choice -we get what they | F 806 | Always available menu restarted and on all dining tables. Daily menu written on board in upper and lower dining rooms. A copy of weekly menu and Always Available menu given to residents choosing to eat in their rooms. Dietary Manager will review the always available menu with residents on admission and quarterly.<br>Staff instructed to ask resident what they would like prior to serving meal.<br>Alternates for Food Dislikes Policy reviewed and updated.<br>Staff re-education will be completed at all staff meetings scheduled for 11-9-21 and 11-10-21. Dietary Manager will audit menu boards 2x/day x 1week then 3x per week x 2 weeks. QAPI committee will do random audits of 5 residents per month r/t food choices at meals. QAPI committee will review every month and make further recommendations.<br>Dietary Manager/designee will be responsible for overall compliance. | |

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| F 806 | Continued From page 32 | F 806 | | |

serve us." R34 informed the group that if they didn't like what they received, they could ask for something else. R55 stated she did not know that. R34 stated "we used to have a choice, but not anymore." No one could remember when they stopped being able to select their food for meals. Furthermore, no one was aware if there was an alternative menu to select from if they didn't like the main entree. R34 stated they used to have one, adding "if we didn't like something, we could get something else." All residents in attendance indicated they would like more than one food choice for lunch and dinner, either by saying yes or nodding affirmatively. R53 stated "that would be good...food is something that is important to us."

During a interview on 9/22/21, at 1:57 p.m., dietary director (DD)-G was asked to describe the process by which residents selected food options for lunch and dinner. DD-G stated residents received a monthly menu and received what was listed on the menu for that day. DD-G stated some residents told nursing if they wanted something else and nursing told dietary. DD-G stated if a resident received a meal they did not like, they could ask for something else, but admitted not all residents would know that. DD-G stated they used to give residents a menus to select their food for lunch and dinner, but that had stopped last year when the pandemic started and was never resumed. DD-G admitted meal time was important to residents as were food choices. DD-G admitted a resident might be disappointed when their meal was placed in front of them but would not tell anyone. DD-G also admitted that if a meal had to be changed, a resident may end up eating alone as other residents at the table would be done eating by the time the resident received

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| F 806 | Continued From page 33<br>their meal. DD-G stated "pre-Covid we had an 'always available' menu which was laminated and placed on each table which included food such as soup and sandwiches. However, that was also stopped last year and not resumed..."I don't know why."<br><br>During the same interview, DD-G stated when residents were admitted to the facility, she met with them to learn their food preferences. An "Admission Visit" form completed by DD-G for each of the residents R13, R5, R53, R42, R34, R55, R25 and R29 was reviewed. The form included a column for special requests and a column for dislikes. Examples of special requests for lunch and dinner included: likes hotdishes, would prefer salad instead of barbeques, likes sauerkraut, likes water with all meals, likes chocolate ice cream. Dislikes included: milk, mashed potatoes, oysters, and barbeques. DD-G admitted the information obtained at this interview would not be sufficient in determining whether a resident would like what was on the lunch or dinner menu. DD-G stated she could see how going back to allowing residents to select their meals options would improve the meal experience for them.<br><br>On 9/24/21, at 10:08 a.m., R55 stopped surveyor in the hallway and stated "Until the meeting with you, I didn't know you could ask for something else if you didn't like the food. I got fish the other day -- I don't like it, so I asked for something else. I wish I would have known that sooner."<br><br>Facility policy on resident food choices for meal service was requested but not received. | F 806 | | |
| F 880 SS=F | Infection Prevention & Control | F 880 | | 12/1/21 |

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| F 880 | Continued From page 34<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a | F 880 | | |

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| F 880 | Continued From page 35<br>resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>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 by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including masks, were worn correctly. This had the potential to affect all 58 residents who resided in the facility. | F 880 | R33 was not affected by staff not having mask on properly. All residents have the potential to be affected by staff not wearing masks appropriately.<br>QAPI Committee met on 10/27/21 and conducted a root cause analysis regarding mask wearing, developed audit forms and on the spot correction procedure.<br>Leadership instructed on 10/27/21 to correct any staff that are observed to not | |

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| | 245407 | A. BUILDING _____ B. WING _____ | C 09/24/2021 |

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

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| F 880 | Continued From page 36<br><br>Finding include:<br><br>On 9/20/21 through 9/22/21, the following mask observations were made: of staff in the facility who were not appropriately wearing face masks.<br><br>Upon entrance to the facility on 9/20/21, at approximately 2:45 p.m., several of the facility leadership team greeted surveyors in the conference room including the administrator whose mask was below his nose.<br><br>During observation on 9/21/21:<br>9:29 a.m.: Nursing assistant (NA)-F was at the 2nd floor nurses station talking to several unidentified co-workers with her mask below her nose.<br>11:47 a.m.: Social worker (SW)-A was walking in the main hallway past a section of resident rooms with her mask below her nose.<br>12:56 p.m.: Dietary aide (DA)-A was in first floor empty dining room with her mask below nose, wiping tables.<br>2:25 p.m.: While standing within a foot of R33's s face, NA-F spoke directly into R33's face with her mask below her chin. R33 was not masked.<br><br>During observations on 9/22/21:<br>9:34 a.m.: (NA)-G was sitting at a table in the dining room area across from the nursing station with her mask below her nose. Residents were nearby in wheelchairs.<br>9:42 a.m.: While in the 2nd floor nurses station, standing next to registered nurse (RN)-D and talking to her, ward clerk (WC)-E had her mask below nose.<br>10:35 a.m.: (WC)-F was sitting in 1st floor nurses station with mask hanging from one ear. | F 880 | be wearing mask properly.<br>Will review policies on standard and transmission based precautions, develop and implement policies and procedures related to source control masks, proper use of gowns, donning and doffing ppe, and include crisis standards of care, contingency standard of care and standard care by 11/5/21.<br>Training and competency on infection control practices which will include appropriate PPE use, donning and doffing of PPE, and transmission based precautions will be completed by Director of Nursing and Staff Development RN at staff meetings on 11-09-21 & 11-10-21.<br>Residents will receive education on infection prevention and mask wearing by 11/12/21. Education on infection prevention including mask wearing and handwashing will be sent to resident representatives by 11/12/21. Mask wearing education, handwashing and infection prevention program will be included in admission packet.<br>Leadership will conduct routine audits on all shifts four times a week x 1 week, then twice a week until 100% compliance of staff, residents, and visitors.<br>Leadership will conduct real time audits on proper use of gowns and proper donning and doffing of gown when a resident is placed in quarantine or transmission based precautions. Facility currently does not have any residents that require this.<br>Director of Nursing/designee will review results of audits and monitoring with the QAPI Committee. | |

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| F 880 | Continued From page 37<br><br>During an interview on 9/22/21, at 10:40 a.m., the director of nursing stated the expectation for all staff was to wear masks properly, with the mask covering both the nose and mouth. The DON stated she had told staff this, but there was still lack of compliance, adding, "they get hot, or take a drink and pull it down." DON was informed of multiple observations of masks worn below nose and mouth, none of when an employee was taking a drink. DON acknowledged she was aware of this and stated she has addressed it with staff when she observed this.<br><br>Facility policy on masking was requested and policy titled Policy for Suspected or Confirmed Coronavirus, undated, was received. Policy indicated staff would use appropriate PPE when interacting with residents per CDC (Center for Disease Control) guidance. All facility staff were required to wear a face mask while in the facility. | F 880 | QA&A will review at next meeting on 1/27/21.<br>Director of Nursing/designee will monitor overall compliance. | |
| F 921 SS=E | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure fans used in resident hallways and resident rooms (R8, R28, R37, R29) were kept in a clean and sanitary manner and free of dust and debris. This had the potential to affect residents residing on second floor and those who used laundry services at the facility. | F 921 | R8,R28, R37, 2nd floor nurses station, R29, laundry room fans were cleaned. Wall fans in laundry room and tub room were replaced.<br>Housekeeping and maintenance checked all fans in building and cleaned or replaced fans as needed.<br>Cleaning of fans was added to the | 10/28/21 |

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| F 921 | Continued From page 38<br>Findings include:<br><br>The following observations of fans were made:<br><br>1. On 9/20/21, at 3:46 p.m., in R8's room, a black Air King brand floor fan, approximately 18 - 20 inches in diameter was observed oscillating; fan had moderate amount of light colored, fuzzy gray material on blades and grates.<br>2. On 9/20/21 at 3:58 p.m., in R28's room, a white Lasko brand desk-top fan, approximately 15 -18 inches in diameter was observed oscillating; fan had a moderate amount of fuzzy dark material on blades and grates.<br>3. On 9/20/21, at 4:09 p.m., in R37's room, a Comfort Zone brand floor fan approximately 12-15 inches in diameter was observed oscillating; fan had dark material on the edges on the gray colored blades and fuzzy dark material on the grates.<br>4. On 9/20/21, at 4:16 p.m., at the second floor nurses station, a black Comfort Zone brand desk-top fan was observed facing towards residents in the dining room/common area. There was light gray, fuzzy material on the blades and grate. The fan was not on.<br>5. On 9/20/21, at 4:46 p.m., in R29's room, a small white desk-top fan was sitting on the floor oscillating, facing R29 as he sat in his recliner with his legs down. The fan had heavy gray material on blades and grate. R29 had wounds to both legs that required dressings. Legs were covered with wraps at the time.<br>6. On 9/20/21, at 4:51 p.m., a white Lasko brand fan, approximately 20-24 inches in diameter and mounted from the ceiling in the tub room on 2nd floor, was oscillating at a high speed. The blades and grates were heavily soiled with dark material. There was no one in the tub | F 921 | housekeeping monthly checklist for all rooms.<br>Maintenance Director will review monthly checklist and monitor overall compliance.<br>QAPI committee will audit 5 fans per month and make further recommendations. | |

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| F 921 | Continued From page 39 | F 921 | | |

room at the time.
7. On 9/23/21, at 7:57 a.m., while in the clean laundry area, observed a white Lasko brand wall fan, approximately 12 inches in diameter, blowing toward dryers and folding counter. The fan was heavily soiled with gray fuzzy material. Observed a Comfort Zone brand black floor fan blowing in same direction with a moderate amount of gray fuzzy material on blades and grates. When asked who cleaned the fans, neither laundry (L)-C or (L)-D knew.

During an interview on 9/23/21, at 8:06 a.m., with maintenance director (MD)-A and maintenance (M)-B, M-B stated nursing informed maintenance when a fan needed to be cleaned, and stated they were not on a routine cleaning schedule. Maintain director was not aware of a fan cleaning policy.

During an interview on 9/23/21, at 10:16 a.m., the director of nursing (DON) was not sure who was responsible for cleaning fans -- nursing could tell housekeeping or maintenance, and admitted dirty fans directed towards residents and in resident rooms should be clean to prevent airborne pathogens.

Facility policy on cleaning fans was requested but not provided.

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| | 245407 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/22/2021** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/23/2021. At the time of this survey, ST JOHNS LUTHERAN HOME was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

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

Electronically Signed | 10/28/2021

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| | 245407 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/22/2021** |

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>ST JOHNS LUTHERAN HOME is a two-story building with a partial basement and was constructed at five different times. The original building was constructed in 1961 and was determined to be Type II ( 000 ) construction. In 1972 an addition was added and was determined to be Type II ( 000 ) construction. In 1987 an addition was added and was determined to be Type II ( 222 ) construction. In 1991 an addition | K 000 | | |

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| | 245407 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/22/2021** |

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| K 000 | Continued From page 2<br>was added and was determined to be Type II ( 000 ) construction, with a portion of the addition being of Type V ( 111 ) construction. In 2000 an addition was added and was determined to be Type III ( 211 ) construction.<br><br>Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, resident rooms, and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 65 beds and had a census of 57 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 271 SS=E | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.<br>18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced | K 271 | | 12/8/21 |

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| K 271 | Continued From page 3<br>by:<br>Based on observation and staff interview, the facility failed to maintain the exit discharge in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, 7.7. These deficient conditions could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that the Dining Room Exit Door egress to grade had a vertical displacement greater than one-half inch, and the concrete was degraded and breaking up, presenting a fall and trip hazard.<br><br>2. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that the two Chapel Exit doors egress to grade had a vertical displacement greater than one-half inch and horizontal separation of 1-inch between concrete slabs presenting a fall and trip hazard.<br><br>These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery. | K 271 | The walking surfaces of the chapel exits and the dining room egress pad will be leveled. This will be completed through the utilization of cement. It will eliminate the 1/2 inch rise in the cement.<br>Director of Maintenance will monitor and is responsible for follow up.<br>Director of Maintenance will educate staff at all staff meeting to be aware of any shifts of cement exit areas and report to Maintenance.<br>Administrator to work closely with Maintenance Director to ensure completion of this task on time and to be completed correctly. | |
| K 324<br>SS=E | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small | K 324 | | 10/28/21 |

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| K 324 | Continued From page 4<br>appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, documentation review, and staff interview, that the facility failed to maintain cooking facilities in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 19.3.2.5.3 and 19.3.2.5.5. These deficient conditions could have a patterned impact on the residents within the facility.<br><br>Findings Include:<br><br>1. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that the 2 North warming kitchen stove was found operational, unattended, and readily accessible to the resident corridor.<br><br>2. On 09/23/2021 between 10:30 AM to 03:30 | K 324 | During a walk through the 2-North warming kitchen stove was operational and unattended.<br>" The stove was immediately turned off with the key.<br>" The key location was changed to a cabinet location not visible/accessible to residents.<br>" A sign was made to remind staff the stove is to be turned off after every use.<br>" All staff utilizing the stove have been re-educated regarding proper procedures for using the stove.<br>" Director of Maintenance and the charge nurse will monitor the stove so proper procedures are followed.<br>Lack of Documentation regarding annual | |

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| K 324 | Continued From page 5<br>PM, it was revealed during documentation review that no current annual or previous semi-annual inspection documentation was available for review associated with the range hood suppression system for the range in the main kitchen.<br><br>These deficient conditions were confirmed by the Facility Administrator at the time of discovery. | K 324 | or semi-annual inspection of the range hood suppression system.<br>" The regular inspection was not competed timely due to COVID.<br>" Inspection was completed June 7, 2021<br>" A sub- contractor completed the inspection, failed to send a completed report to the facility.<br>" Upon contacting Brothers Fire & Security they sent a report that was forwarded to the Fire Marshal on 10/24/2021.<br>" The Director of Maintenance will monitor this on a bi-annual basis. Inspections are scheduled for future reviews. We are hopeful COVID will not be a factor.<br>" Corrected 10/24/2021. | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for | K 353 | | 10/31/21 |

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| K 353 | Continued From page 6<br>any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, documentation review, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2. NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient conditions could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 09/23/2021, between 10:30 AM to 03:30 PM, it was revealed during documentation review that the sprinkler system annual inspection was past due. The most recent documentation present for review was 09/01/2020.<br><br>2. On 09/23/2021, between 10:30 AM to 03:30 PM, it was revealed during documentation review that no quarterly inspection documentation was available for review.<br><br>3. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that the Kitchen sprinkler heads exhibited signs of oxidation, were covered with debris, and the walk-in freezer sprinkler head was ice encapsulated. | K 353 | 1.Annual Inspection Past Due<br>2.Quarterly Inspection Past Due<br>"Inspection was completed 6-7-2021 by sub-contractor. Report given to facility.<br>"Both inspections are now scheduled with Brothers Fire & Security. This will put us on a regular inspection cycle once again.<br>"Maintenance Director will add to the preventative maintenance program and monitor testing bi-monthly with Brothers.<br>"Completed 10/26/2021<br>3.Kitchen sprinkler heads exhibited signs of oxidation. Sprinkler head in freezer was ice encapsulated.<br>"Brothers Fire & Security has been called. We will schedule a complete building inspection of all sprinkler heads.<br>"Maintenance Director will manage and monitor until the inspection is complete.<br>"Plan to complete before 11-3-2021.<br>Freezer sprinkler Head<br>-Sprinkler was immediately cleared off of ice build up.<br>-Director of Dietary will monitor weekly for any build up.<br>-Opening the door causes condensation build up. We have asked Brothers Fire & Security for any suggestions on how to prevent this.<br>-Closed and completed 10/25/2021.<br>4.Items placed closer than 12 to sprinkler heads.<br>-All items in identified areas were removed or moved to a safe distance. | |

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| K 353 | Continued From page 7<br>4. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that items were placed closer than eighteen inches to the sprinkler head(s) in the following locations: Clean Linen closet adjacent to 1-South Nurses Station, Romm 184, Room 140, 2-North Staff Lounge closet, Room 253, and Room 234.<br><br>5. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that sprinkler head(s) exhibited signs of oxidation in the following locations: Room 423, 2-North Housekeeping closet, Room 307-A, and Room 307-B.<br><br>These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery. | K 353 | -The top shelf was removed in those identified rooms to prevent any further safety concern.<br>-All housekeeping staff have been educated to be aware of this policy.<br>-A series of 4 All Staff Meetings will be held by 11-10-2021 to re-educate staff.<br>-The Director of Maintenance and Administrator will monitor this on their facility walk throughs.<br>-Completed 10-25-2021.<br><br>5.Facility Walk Through. Some sprinkler heads show3ed signs of oxidation, #423, 307- A & B.<br>-Brothers Fire & Security has been called. They will replace sprinkler heads in #423 and #307 A & B. Additionally, they will do a full facility audit of all sprinkler heads with the Dir. Of Maintenance.<br>Note: Oxidation does not mean they will not function. We intend to replace every head showing oxidation.<br>Maintenance Director will work with Brothers to ensure they inspect every sprinkler head on each annual inspection. This will be completed ASAP-by 10-31-2021. | |
| K 372 SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct | K 372 | | 10/28/21 |

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| K 372 | Continued From page 8<br>penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to test smoke dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.5.4 and 8.5.5.4.2, and per NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protective, section 6.5.2 This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during documentation review that no records were available to review to confirm when smoke damper testing was last completed and the outcomes at the time of testing.<br><br>This deficient practice was confirmed by the Maintenance Director at the time of discovery. | K 372 | Report was not given to facility.<br>Brothers completed the inspection 6-7-2021. No issues were noted.<br>Dir. Of Maintenance will monitor.<br>Completed 6-7-2021. | |
| K 374 SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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 | K 374 | | 10/25/21 |

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| K 374 | Continued From page 9<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This REQUIREMENT is not met as evidenced by:<br>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 and 8.5.4 This deficient condition could have a widespread impact on the resients within the facility.<br><br>Findings include:<br><br>On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that upon testing of the smoke barrier doors adjacent to BT 109-1 and the 2 South smoke barrier doors, they did not self-close and seel to resist the passage of smoke.<br><br>This deficient practice was confirmed by the Maintenance Director at the time of discovery. | K 374 | Smoke barrier doors BT-109 and 2 South did not self close and seal.<br>The doors were immediately adjusted.<br>New seal strips were installed.<br>Director of Maintenance will monitor all fire doors monthly.<br>Corrected 10/25/2021<br>We will observe fire doors at the time of fire drills. | |
| K 712<br>SS=C | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>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 | K 712 | | 11/1/21 |

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| K 712 | Continued From page 10<br>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.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during documentation review that fire drills records identify a lack of varied times for 1st and 2nd shifts during all four quarters. The noted times were as follows: 1st shift - 3:30 PM, 3:15 PM, 3:32 PM, and 3:47 PM; 2nd shift - 6:43 PM, 6:37 PM, 6:31 PM and 6:15 PM.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 712 | Fire Drills-There was a lack of varied times on both the first and second shift.<br>Note: Even with random drill times, the same staff are present. Fire drills were run timely.<br>The Director of Maintenance will establish a fire drill schedule that will reflect various shift times for both the first and second shifts.<br>Administrator and Director of Maintenance will monitor drills to ensure they are run at various times.<br>A yearly schedule for fire drills will be completed by 11-1-2021 with a variation of times. | |
| K 761 SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are | K 761 | | 10/25/21 |

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| K 761 | Continued From page 11<br>routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to inspect and maintain door assemblies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 8.3.3.1, and NFPA 80 (2010 edition), sections 5.1, 5.2. These deficient conditions could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during documentation review that the records presented for review only identified six points of inspection for each door. The documentation was not dated, and the completion date could not be confirmed by the Maintenance Director.<br><br>2. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during a walk-through of the facility that the 2nd Floor SW Wing Fire Doors, that separate the skilled nursing care from the adjacent day-care operations, did not self-close and latch upon testing.<br><br>These deficient conditions were verified by the Maintenance Director. | K 761 | Tension of doors was adjusted. Doors close and latch.<br>Maintenance Director to monitor all self closing fire doors.<br>Note: The AC back pressure affects door closure in this area | |

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| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>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 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.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to complete receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 through 6.3.3.2.4 and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during documentation review that no documentation was presented for review to | K 914 | Facility states testing was completed. Paperwork not found by the new Dir. Of Maintenance.<br>Testing equipment will be purchased by 10/29/2021.<br>Maintenance Director will test/monitor testing.<br>All testing will be completed by 11/15/2021. | 11/15/21 |

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| K 914 | Continued From page 13<br>confirm that electrical outlet testing of resident rooms had been completed.<br><br>This deficient condition was verified by the Maintenance Director. | K 914 | | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power | K 918 | | 12/1/21 |

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| K 918 | Continued From page 14<br>source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, 5.6.6 This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 09/23/2021, between 10:30 AM to 03:30 PM, it was revealed during a walk-through of the facility that the installation date of the battery for the emergency power supply system was November 2014, which is outside of the manufacturer's recommendation.<br><br>2. On 09/23/2021, between 10:30 AM to 03:30 PM, it was revealed during a walk-through of the facility that a remote manual stop station for the emergency power supply system could not be located.<br><br>This deficient condition was verified by the Maintenance Director. | K 918 | 1. Emergency Power. Battery paperwork showed most recent replacement of 2014, which is outside of manufacturer□s recommendation.<br>" Battery was not marked.<br>" Paperwork located: Battery was replaced 1-6-2021.<br>" Information sent to Fire Marshal<br>" Maintenance Director will monitor<br>" Completed 10/25/2021<br>2. Remote Manual stop station for generator was not located<br>" Electrical contractor called 10/22/2021<br>" Emergency switch ordered.<br>" Maintenance Director will monitor.<br>" Completion date: 12-1-2021 | |
| K 920 SS=E | Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords | K 920 | | 10/21/21 |

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| K 920 | Continued From page 15<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during facility walk-through of the facility that a 2-to-6 multi-tap electrical adapter was in use in the 2 South Nurses Station | K 920 | 1. An adapter was in use in the 2 South nurse□s station -charting room.<br>" Adapter removed<br>" Educated nursing to the potential for fire<br>" Dir. Of Maintenance to monitor<br>" Completed 10/21/2021<br>2. Extension Cord in room #216<br>" Removed 9/22/2021<br>" Extension cord use will be discussed Nov. 9 & 10 at the 4 All Staff Meetings.<br>" Maintenance to monitor<br>" Completed: 9-22-2021<br>3. Two power strips in Administrative Office under desk | |

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| K 920 | Continued From page 16<br>- Charting Room.<br><br>2. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the facility walk-through of the facility that an extension cord was in use in RM 216.<br><br>3. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the facility walk-through of the facility that power-strips were daisy-chained together in the Admin Office.<br><br>4. On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the facility walk-through of the facility that high amperage appliances were connected to a power strip in the Business Area.<br><br>This deficient practice was confirmed by the Maintenance Director at the time of discovery. | K 920 | " One power strip removed<br>" Administrator to monitor<br>" Maintenance educated Administrator<br>" Administrator took corrective action<br>" Completed 9-22-2021<br>4. Microwave connected to power strip in business office area.<br>" Removed power strip<br>" Educated all business office staff of potential of fire<br>" Administrator to monitor<br>" Completed 9/22/2021 | |
| K 923 SS=F | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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. | K 923 | | 11/10/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245407 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/22/2021** |

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

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|---|---|---|---|---|
| K 923 | Continued From page 17<br>Less than or equal to 300 cubic feet<br>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.<br>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."<br>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.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.3.4, 11.6.2.3, 11.6.5<br>This deficient condition could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 09/23/2021 between 10:30 AM to 03:30 PM, it was revealed during the walk-through of the facility that Room 138 - Med Gas Storage had mixed storage of cylinders (empty/full), and upon testing, the door did not self-close and latch.<br><br>This deficient practice was confirmed by the | K 923 | " Self close unit and new latch installed the same day 10-22-2021<br>" Maint. Director to educate staff<br>" All staff meeting on Nov. 9 & 10 will address proper storage of oxygen.<br>" Completed 10/22/2021 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245407 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/22/2021** |

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|---|---|---|---|---|
| K 923 | Continued From page 18<br>Maintenance Director at the time of discovery. | K 923 | | |