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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TQ4G

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 **06/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Dobie, HFE NE II 06/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/06/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 21, 2018

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

RE: Project Number S5407026

Dear Mr. Goeritz:

On June 7, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 7, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	06/07/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 4th through June 7th, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 6/4/178 - 6/7/18 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	F 577		6/28/18

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

Electronically Signed | 06/28/2018

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

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F 577	Continued From page 1 §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure survey results were posted in a location easily accessible to residents and visitors. This had the potential to affect all 65 residents residing in the facility and their visitors. Findings include: The facility's survey results were observed on 6/6/18, at 1:05 p.m. in a book located in a clear holder on the wall by the nurses' station on the main floor. The clear holder containing the book was too high up, so residents in wheelchairs would be unable to access it. During resident council meeting on 6/6/18, at 10:50 a.m. All ten residents in attendance indicated they were not aware where the facility's federal nursing home survey results were located.	F 577	Prior to survey completion, survey book and holder were lowered to meet requirements of wheelchair accessibility for residents. Location of survey results was reviewed at Resident Council on 6/25/18. It will continue to be reviewed at Resident Council on an ongoing basis.	

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F 577	Continued From page 2 During interview on 6/6/18, at 1:11 p.m., ward clerk verifies a resident in a wheelchair could not access the survey results. During interview on 6/6/18, at 1:13 p.m., social worker agreed that a resident in a wheelchair could not access the survey result located in book as the holder containing the book is located too high on the wall for a resident to be able to reach while sitting in a wheelchair.	F 577		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving assistance was provided for 1 of 1 resident (R12) reviewed for activities of daily living, who was dependent upon staff for assistance with grooming. Findings include: R12's annual Minimum Data Set (MDS) assessment indicated R12 had severe cognitive impairment, was totally dependant of staff for locomotion on and off the unit, and required extensive assistance with bed mobility, transfer, toilet use, dressing, eating, and personal hygiene. R12's care plan dated 3/20/18 indicated the resident needed complete assistance with ADL's	F 677	It is the policy of St. John□s that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and persona and oral hygiene. R12 facial hair was shaved on 6/7/18 at time of survey. Resident care plans reviewed to ensure shaving is addressed and assignment sheets updated to reflect shaving needs. Reviewed and revised Resident Cares policy and procedure to include shaving. Developed a bathing checklist for nursing assistants. Nursing staff educated on Resident Cares policy and bathing checklist. Random audits of 6 residents will be	7/27/18

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F 677	Continued From page 3 related to Alzheimer's dementia with behaviors and cognitive deficits. The care plan further indicated R12 required extensive physical assistance of 1-2 staff with personal hygiene. On 6/4/18, at 10:54 a.m. R12 was observed reclined in a geri chair in the dayroom positioned in front of the aviary. R12 had long random hairs noted on her chin and sides of face that were approximately 1-2 centimeters in length. During observations on 6/5/18, 6/6/18, and 6/7/18, R12 continued to have unshaven facial hair. When interviewed on 6/7/18, at 3:49 p.m. trained medication aide (TMA)-E stated female residents are shaved on bath day and in between as needed. TMA-E observed R12 who was seated in her geri chair in the dayroom and confirmed the resident had long facial hairs. TMA-E checked with nursing assistant (NA)-A who confirmed R12's bath day was on Monday evenings. NA-A also confirmed that shaving was a part of bathing. TMA-E confirmed R12 was cooperative with being shaved and stated she would attempt at this time. When interviewed on 6/7/18, at 4:47 p.m. the director of nursing (DON) stated she would expect female resident to be shaved on their bath day if needed.	F 677	conducted weekly x4, then monthly x3. QAPI committee will review for compliance, analysis and further recommendations. QA&A Committee will review at next meeting on 7/26/18. Correct will be monitored by DON/Designee.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		7/27/18

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F 679	Continued From page 4 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with activity engagement for 1 of 2 residents (R12) reviewed who was dependent on staff for activity involvement. Findings include: R12's annual Minimum Data Set (MDS) assessment indicated R12 had severe cognitive impairment, was totally dependant of staff for locomotion on and off the unit, and required extensive assistance with bed mobility, transfer, toilet use, dressing, eating, and personal hygiene. The staff assessment for activities indicated R12 enjoyed listening to music and participating in religious activities or preferences. R12's care plan dated 3/20/18, indicated a potential for activity deficit related to Alzheimer's dx. (diagnosis), dementia with behaviors, anxiety, and agitation. Interventions included to place near music or TV as able for stimulation; invite and assist to scheduled activities on her station for stimulation; assist to entertainment, worship, sensory activities; and provide weekly 1:1(one to one) and sensory activity using picture books, objects, songs, and conversation. On 6/4/18, at 10:54 a.m. R12 was observed reclined in a geri chair in front of the aviary. A	F 679	R12 Care Plan has been updated to reflect an additional weekly 1:1 visit based on her interest/needs. The weekly 1:1 visit is now 2x/weekly instead of 1x/weekly. 1:1 visit will last at least 15-20 minutes at a minimum and provide a variety of stimulation including but not limited to outdoor time, music therapy, or sensory stimulation. This will be ongoing. The weekly 1:1 visit list will be updated to meet the needs of other cognitively impaired residents by offering 1:1 visits 2x/weekly instead of 1x/weekly. This will be ongoing. Cognitively impaired residents will be offered daily activities according to their interests. This will be ongoing. The Activity Department will monitor weekly activity participation by each resident. Residents who attend less than 2x/weekly group programs will be offered an additional 1:1 visit that week based on their preferences. This will be documented in the 1:1 weekly documentation charts. This will be ongoing. The Activity Assistants will be trained to monitor weekly documentation of activities to watch for residents attending less than 2x/weekly programs. If they find a resident has attended less than 2x/weekly	

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F 679	Continued From page 5 hymn sing activity was being conducted in the chapel at that time. On 6/6/18, at 10:02 a.m. R12 was observed reclined in a geri chair in the dayroom. Catholic mass was scheduled for 10:00 a.m. in the chapel. At 10:12 a.m. activity aide (AA)-A moved R12 in front of the aviary in the dayroom telling the resident she was moving her so she could hear the birds sing. AA-A also informed R12 that later she would take her outside for a walk. AA-A then went and sat with 2 other residents at a table across the from R12 in the dayroom and assisted the other residents with painting their fingernails. At 10:51 a.m., R12 was taken outside in her geri chair by AA-A; at 10:57 a.m. AA-A brought R12 back inside the building to the dayroom and positioned her chair in front of the TV which was off. R12 was not given the opportunity to attend Catholic mass and was outside with AA-A for a 1:1 visit for only 6 minutes. On 6/7/18, R12 was continuously observed from 9:31 a.m. until 11:02 a.m. reclined in a geri chair in the dayroom in front of the TV which was on. A bible study activity was conducted at 10:00 a.m. in the chapel; R12 was not given the opportunity to attend. On 6/7/18, at 1:18 p.m. R12 was observed in her room in geri chair in a lying position with eyes closed and appeared to be sleeping. R12's roommate was also in the room at that time watching TV. At 1:57 p.m., a music activity from an outside entertainer was beginning in the chapel; R12 remained in her room. At 2:11 p.m. and 2:20 p.m., R12 continued to remain in her room and was awake; the blinds were drawn and the room was dark. At approximately 2:50 p.m.	F 679	programs, they will offer the additional 1:1 visit. This will also be ongoing.	

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R12 was observed reclined in her geri chair in the dayroom positioned in front of the aviary; the music activity continued in the chapel. R12 was not given the opportunity to attend the music activity.

When interviewed on 6/7/18, at 3:30 p.m. the activity director stated staff try to involve R12 in more of the smaller group activities. AD stated during the larger groups R12 would sometimes become agitated and holler out. AD confirmed the resident does attend church services and music activities at times depending upon her mood. AD further stated the resident attended the music activity on 6/5/18 and did ok. AD was not sure why R12 didn't attend the music activity today but would check with her staff. AD stated her expectation with 1:1 activities would be to last at least 20 minutes unless the resident became agitated. AD confirmed R12's 1:1 with AA-A on 6/6/18 should have lasted longer than 6 minutes.

When interviewed on 6/7/18, at 4:13 p.m. the AD stated she had checked with nursing staff who stated R12 had been agitated earlier in the day so they had taken the resident to her room to calm. The staff indicated that seemed to work so they had her remain in her room. Surveyor informed AD that R12 was in her room at 1:18 p.m. sleeping which was approximately 45 minutes prior to the music activity; after the music started the resident was awake in her room. AD agreed staff should have attempted to bring R12 to the music activity to see how she would do. AD also confirmed on 6/6/18 staff should have attempted to bring the resident to catholic mass per her plan of care.

When interviewed on 6/7/18, at 4:47 p.m. the

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F 679	Continued From page 7 director of nursing (DON) stated she would expect residents who are unable to bring themselves to activities to be offered/attempted to attend and also would expect a 1:1 activity to be at least 15 minutes. DON also shared that R12 loved Elvis and the singer who came in today sang all Elvis songs.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provision of consistent monitoring, assessment, and implementation of interventions to promote healing for 1 of 1 resident (R55) reviewed who had pressure ulcers on his heels. Findings include: R55's Minimum Data Set (MDS) dated 5/6/2018, identified R55 had severe cognitive impairment and required extensive assistance for transfers,	F 686	R55 care plan reviewed and clarified when heel protector boots to be worn. Educated staff that heel protectors are to be worn at all times. Staff assignment sheet also updated to reflect this. Updated primary MD on status and OT orders received. Padding applied to metal foot plate. Padding and use of heel protectors has alleviated the direct contact to the metal plate. Continues to use alternating air mattress on bed. Designated RN to monitor pressure ulcer	7/27/18

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F 686	Continued From page 8 bed mobility, and eating. The MDS identified R55 was always incontinent of bladder and bowel, further, R55 was at risk to develop pressure ulcers and had one unhealed stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed) facility acquired pressure ulcer. Interventions identified: pressure reducing device in chair, pressure reducing device in bed, and pressure ulcer care. R55's clinical diagnosis report, revised 3/19/18 revealed R55 had diagnoses of: hemiplegia following cerebral accident affecting right dominant side (CVA), atrial fibrillation and hypertension. R55's physician orders, signed on 4/20/18, identified a wound treatment of benzoin (a topical product applied to wounds to prevent irritation and infection) and protective ointment days and evenings for prevention of skin breakdown to right heel and coccyx (original start date of this order was 2/9/18). R55's admission/readmission pressure risk assessment form revised 4/29/18, indicated: Resident scored 14.5 on Braden scale for admission assessment period [moderate risk for skin breakdown]. He requires routine reposition schedule from staff, extensive total assist as he is not able to reposition self adequately. He has risk factors for pressure related problems due to CVA with right hemiplegia, foley catheter, edema, cognitive loss, preferred positioning, aging thin dry skin, unstable medical condition, aphasia, and dependent for mobility. He has fragile area on his gluteal fold and right heel. Staff assess skin with cares and nurse to assess weekly with bath. He requires air mattress on his bed and cushion on	F 686	weekly. Reviewed pressure risk assessments to identify residents at risk or history of pressure ulcers to ensure interventions are being implemented, care plan and assignment sheets are accurate and proper documentation. Facility wound care/pressure ulcer policies reviewed. Staff Development RN educated licensed staff on pressure ulcer assessment, competency and policies. Revised facility wound flow sheet. Designated RN to monitor pressure ulcers and skin concerns weekly. DON/Designee will monitor overall pressure ulcers. QAPI committee will complete audits weekly x4, then monthly x3. QA&A Committee will review at next meeting on 7/26/18.	

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his wheelchair, heel protectors and dressing on right heel for protection. Staff will reposition every two hours and apply protective cream with cares.

R55's care plan, updated 5/10/18, indicated an alteration in skin integrity, related to immobility with right side hemiplegia, incontinence of bowel, foley catheter, edema (mild) dry skin, and unstable medical condition. The goal listed: right heel ulcer will heal without complication within 90 days. Interventions identified: treatment to right heel ulcer, document progress of right heel ulcer weekly with bath, protective ointment to gluteal folds with cares and as needed. air mattress on bed, bilateral heel protectors, (observe frequently as resident will remove them).

R55's tissue tolerance test dated 2/19/18, indicated R55's skin was intact.

R55's nursing progress note, dated 5/18/18, indicated: Will discontinue treatment to heel and coccyx, and use 24 hour moisturizing cream to feet/heels/toes and monitor coccyx during routines skin checks and as needed. During bath this morning callous to right heel peeled off during bath leaving small (<0.5 cm) open area. Pressure areas and skin folds intact.

R55's nursing progress note, dated 5/25/18,indicated: Bath and routine skin check done. Pressure area intact, will continue with current plan of care.

R55's nursing progress note, dated 5/29/18, indicated: Staff noticed a small sore on R55's left heel. Soft heel protector boots applied, will set up treatment.

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The treatment administration record indicated a treatment had been set up 5/29/18, "Tincture of Benzoin followed with lotion rub twice daily to left heel until healed."

R55's nutritional monitoring dated 5/30/18, indicated: Left heel has open area per nursing. Oral intake remains poor-baseline for resident. Weight is 140.8 pounds which is down 1.5% in one month and 6.7% in three months. Will add super cereal to breakfast, whole milk to meals for extra protein for wound healing and vitamin C source at breakfast. Continue on pureed diet with nutritional supplement. Ensure Enlive (a type of high calorie supplement) three times per day.

During observation on 6/5/18, at 3:05 p.m., R55 was sitting in a reclining wheel chair with legs resting on an elevating foot rest with a metal plate to support his feet at the bottom. His heels were resting on the foot rest with slipper socks on, without the heel protectors in place. The edge of the metal plate of his footrest was noted to be in direct contact with the left and right heels.

During observation on 6/6/18, at 8:58 a.m., R55 was sitting in his wheel chair in the dining area after breakfast. R55's heels were resting on the edge of the foot plates on his wheelchair, and R55 was not wearing heel protectors.

During observation of care on 6/6/18, at 9:26 a.m., trained medication aide (TMA)-B stated the left heel wound was treated with betadine, then lotion was applied to R55's heels. "I think it has improved". The right heel ulcer wound was observed at this time and was noted to be 1/2 inch in diameter, with a white center. The wound was observed to be discolored around the edges

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with damaged tissue measuring approximately 7 centimeters x 6 centimeters. TMA-B stated when R55 was put to bed after lunch, he was often restless and staff would get him back up. R55's heel protectors were noted to be on a shelf in his room, rather than having been applied when he was laid down. TMA-B stated he only used the heel protectors at night time. R55 was brought out to the dining area, reclined in the wheel chair with the upholstered legs elevated, and his heels were again noted to be resting along the edge of the metal foot rest causing direct pressure over the heels.

During observation and interview on 6/6/18 at 10:52 a.m., R55 was seated in the dining room and had been observed to remove his left protective heel boot which was laying on the floor next to the wheelchair. The right protective heel boot was still in place. R55 appeared restless, and licensed practical nurse (LPN)-A asked R55 if he was having pain. R55's facial expression indicated he was having pain, but he was unable to describe where. LPN-A took R55 back to his room, where she reapplied his left protective boot. LPN-A called another nursing assistant (NA) into the room to help her to reposition R55 comfortably, and boost him up in the wheelchair. LPN-A got a measuring tool to measure the wounds on R55's heel, and stated the pressure ulcer on the right heel measured 1x1 centimeter (cm), and stated the area around the heel wound was boggy, red, and measured 7 x 9 cm (boggy heels may represent soft tissue damage associated with a stage I pressure ulcer, localized erythema/redness with intact skin). LPN-A measured a pressure ulcer on the left foot which was 1 cm x 4 cm, with an area of white, discolored tissue surrounding the pressure area

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that measured 3 centimeters in diameter. The entire left foot was observed to be very red. Further LPN-A confirmed that when the metal plate was added to the wheelchair, R55 puts his feet on the edge of the plate, resting his heels on the edge. LPN-A verified that she would be calling to update the physician about the pressure ulcers, and would request an order for occupational therapy to evaluate the wheel chair. "This chair does not work for him".

A subsequent nursing progress note, dated 6/6/18 by LPN-A indicated: Today measured resident's pressure areas on his heels bilaterally. Rt. [right] heel the pressure area is 1 cm x 1 cm. Area that measures around the heel is boggy and red is 7 cm x 9 cm. His foot is rubor in color [a red discoloration of the extremities that can indicate circulatory issues]. Fax sent to [R55's physician] to update her on the pressure areas and that resident is very restless past 5 days. He complains of pain when asked, he is ripping his incontinent products and shredding them. Asked if we can get order for OT [occupational therapy] to evaluate W/C [wheelchair] due to his heels hitting the foot rests. He takes the heel protectors off and kicks them to the floor. Repositioned him many times. Laid him down on his bed but was very restless so he was gotten up and put in his w/c.

During interview on 6/6/18, at 12:08 p.m. the director of nursing (DON) revealed that the licensed nurses were responsible to asses the condition of the wounds with the bath. The information was documented in the nursing progress notes, including measurements and condition of the wounds, treatment, and assessment of the progress or decline. The DON

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confirmed that she was unaware of the condition of the skin on R55's heels, or the measurements that LPN-A took. The DON verified the last assessment of the wounds was on 5/18/18.

During interview on 6/6/18, at 1:04 p.m. LPN-A, also stated that the last time the wounds were documented was 5/18/18.

During observation on 6/6/18, at 1:11 p.m. R55 was seated in the dining area in his wheelchair. R55's right heel protector boot was on, the left heel protector boot was hanging off the metal plate on his wheelchair, and was not covering the area of the pressure ulcer.

During observation on 6/7/18, at 7:19 a.m., R55 was in the dining room with his wheelchair positioned in front of the TV, sleeping in the wheelchair without any protective boots in place and his heels coming into direct contact with the footpedals.

During observation on 6/7/18, at 10:53 a.m., R55 was sitting up in his wheel chair, without protective boots in place to protect his heels. At 12:26 p.m., R55 was transferred to bed for rest, a heel protector boot was placed on his left foot only.

During interview on 6/7/18, at 1:14 p.m.,TMA-F stated she felt communication regarding the residents on the unit was very good, "We are kept updated verbally and in a 24 hour communication book." TMA-F presented a book that included updated information regarding changes in condition, falls, and incidents. TMA-F was aware of the pressure ulcers on both of R55's heels. TMA-F confirmed that she thought that the

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F 686	Continued From page 14 protective boots were only to be worn at night, and stated that she missed the update that he was to wear them 24 hours. The current worksheet for the caregivers to follow was reviewed with TMA-F and indicated that R55 was to wear bilateral protective heel boots at all times. Review of the facility policy entitled: Pressure Ulcer Injury Risk Assessment, dated 1/18 indicated: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. Documentation -The following information should be recorded in the residents medical record utilizing facility forms: 5. The condition of the residents skin (i.e., the size and location of any red or tender areas), if identified. Review of policy entitled Prevention of pressure ulcers/injuries, dated 1/18 indicated: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Monitoring: 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis.	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		7/27/18

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F 755	Continued From page 15 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion for 4 of 4 residents (R20, R26, R30 and R51) reviewed for medication storage. Findings include: On 6/5/18, at 7:27 a.m. registered nurse (RN)-A was observed administering medication to R20 which included 2 Fentanyl patches. RN-A was	F 755	Disposal of Used Fentanyl Patches policy and procedure was reviewed and revised to include a witness verification with proper destruction being flushed via sewer. R20, R26, R30, R51 and any future residents with an order for Fentanyl patches, will have patches disposed of by revised policy. Licensed Nurses and TMA's educated on revised Fentanyl Patch Destruction policy	

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F 755	Continued From page 16 observed to remove the existing Fentanyl patches off R20's upper back, fold them in half, and deposit them into a small sharps container. RN-A then dated the new Fentanyl patches and applied to R20's upper back. When interviewed following administration, RN-A indicated she would sign off in the eMAR (electronic medication administration record) that the old Fentanyl patches were removed and the new Fentanyl patches administered. Review of R20's signed physician orders dated 6/1/18, included: Fentanyl 25 mcg (micrograms)/1 hr (per one hour) patch, extended. 1 patch. Transdermal q (every) 72 hrs every 3 days and Fentanyl 12 mcg/1 hr patch, extended. 1 patch. Transdermal q 72 hrs every 3 days. Review of the Order by Order Code printed 6/7/18, indicated R26, R30, and R51 also had physician orders to receive a Fentanyl patch every 3 days for pain. When interviewed on 6/7/18, at 9:40 a.m. RN-B confirmed when Fentanyl patches are removed they are placed in a sharps container by the nurse removing the patch and signed off in the eMAR that the patch had been removed and disposed of. When interviewed on 6/7/18, at 12:07 p.m. RN-C confirmed when Fentanyl patches are removed they are put into the sharps container and signed out on the eMAR that they were removed and destroyed. When interviewed on 6/7/18, at 1:37 p.m. the director of nursing confirmed the process for	F 755	and procedure. QA&A Committee will review revised policy at next meeting on 7/26/18. DON/Designee will monitor destruction process weekly x6.	

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disposing of used Fentanyl patches was to dispose of in a sharps container by the nurse removing/destroying the patch and signed off in the eMAR. DON confirmed there were not 2 staff witnessing destruction and also confirmed the used Fentanyl patches could be retrieved from the sharps container and there would not be a way to track if this had been done.

A policy on disposal of Fentanyl patches was requested. DON supplied surveyor with 2 policies, one from Thrifty White Pharmacy (the pharmacy the facility utilized) and a facility policy.

The Thrifty White Pharmacy policy titled, Disposal of Fentanyl (Duragesic) Patches included:
1) Disposal of a Fentanyl patch that has been on a resident and has fallen off or has been removed in order to apply another patch. a) The Fentanyl patch should be folded (so that the adhesive side adheres to itself) or placed onto a tissue paper (so that the adhesive side adheres to the disposable tissue paper). b) Immediately flushed into the sewer system in the presence of a licensed nurse and a witness. 1. Placing the patches in sharps containers or other biohazard disposal containers is not acceptable as a used fentanyl patch is not to be considered infectious waste. 2. Using a medication waste hauler to dispose of fentanyl patches is not an option due to Federal Drug Enforcement Administration (DEA) regulations. c) Destruction and witness of destruction must be documented on the medication administration record (MAR) or other appropriate documentation record in order to provide the facility with appropriate tracking of patch destruction in patient records.

The undated facility policy titled, Transdermal

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 _____	06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 18 Medication Patches/Disks/Pads included: 4. Remove the used patch and dispose of it safely, in the Sharps container (not in the residents waste basket) - it contains residual medication that could harm others.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/07/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 07, 2018. At the time of this survey, St. John's Lutheran Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: The original building was built in 1961 and was determined to be of Type II(000) construction; The 1st Addition was built in 1972 and was determined to be of Type II(000) construction; The 2nd Addition was built in 1987 and was determined to be of Type II(222) construction; The 3rd Addition was built in 1991 and was determined to be of Type II(222) construction, with a portion of the Addition being of Type V(111) construction; The 4th Addition was built in 2000 and was determined to be of Type III(211) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detectors in all Resident Rooms. The facility has a capacity of 85 beds and had a census of 66 at time of the survey.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/07/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		