



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 5, 2025

Administrator

St John Lutheran Home

201 SOUTH COUNTY ROAD 5

SPRINGFIELD, MN 56087

RE: CCN: 245407

Cycle Start Date: May 14, 2205

Dear Administrator:

On July 10, 2205, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 5, 2025

Administrator

ST JOHN LUTHERAN HOME

201 SOUTH COUNTY ROAD 5

SPRINGFIELD, MN 56087

Re: Reinspection Results

Event ID: TWNB12

Dear Administrator:

On July 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 27, 2025

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

RE: CCN: 245407
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 14, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by November 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

St John Lutheran Home

May 27, 2025

Page 4

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping".

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

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

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/14/2025
NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	E 000			
	On 5/12/25 to 5/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 5/12/25 through 5/14/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54073888C (MN00106529). 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 regulations has been attained.				
F 656	Develop/Implement Comprehensive Care Plan	F 656			7/3/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2025

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

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F 656	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and implemented to include of post-traumatic stress disorder (PTSD) triggers and interventions for 2 of 2 residents (R10 and R23) who had a diagnosis of PTSD. Findings include: R23's face sheet printed 5/14/25, included diagnoses of Parkinson's disease (progressive neurodegenerative disorder that affects movement), psychological trauma, dementia, and major depressive disorder. R23's annual Minimum Data Set (MDS) dated 3/2/25, indicated R23 had moderate cognitive impairment, no behaviors and required moderate assist to stand, toileting substantial to maximal assist of 1 and was able to walk 150 feet with touching and standby by assist. PTSD was not checked as an active diagnosis. Medications included antipsychotic and antidepressant use. R23's plan of care dated 8/6/24, included a potential for mood deficit related to dementia, Parkinson's disease, depression and anxiety. Interventions included keep resident and family	F 656	Care plans for R10 and R23 were updated on 5/13/25 to include ptsd, any triggers or interventions. All residents have the potential to be affected. Audits of all resident care plans will be completed to ensure it includes ptsd, any triggers or interventions. Reviewed and updated Comprehensive Care Plan and Trauma Informed Care policies. Revised the Trauma Informed Care Screening form to include care plan updated section. Education of all interdisciplinary staff that complete care plans to be completed by 6/27/25. Director of Nursing or designee will complete audits of all new admission care plans x 4 weeks and will report findings to QAPI committee for review and further recommendations. Director of nursing/designee will monitor overall compliance.		

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F 656	Continued From page 3 updated, encourage participation in activities of interest, support visits for mood and adjustment, mental health provider visits routinely, allow resident to verbalize and express feelings and frustrations. Medicate with Pristiq (antidepressant), Seroquel (antipsychotic), Remeron (antidepressant), Wellbutrin (antidepressant), Effexor (antidepressant, antianxiety), testosterone injection, olanzapine (antipsychotic) and melatonin (hormone that plays a role in sleep) per MD orders. R23's care plan failed to indicate PTSD triggers and interventions. On 5/13/25 at 12:51 p.m., registered nurse RN-C stated she was not aware of R23's history of trauma. RN-C stated R23 has a lot of anxiety and does not like being at the facility. RN-C is not aware of any triggers and confirmed there is no plan of care for PTSD. On 5/13/25 at 12:59 p.m., nursing assistant (NE)-E stated she was aware of R23's history of PTSD but was not aware of triggers. NA-E stated she felt R23 had more anxiousness than PTSD and when he is anxious she goes and gets the nurse. On 5/13/25 at 1:07 p.m., NA-F stated she was not aware of R23's history of PTSD but is aware he has a lot of anxiousness. NA-F could not state what triggers the PTSD or periods of anxiousness. NA-F stated we try to distract him by taking him outside or to an activity or we go get the nurse. On 5/13/25 at 12:06 p.m., the director of nursing (DON) confirmed she was aware of R23's history	F 656			

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F 656	Continued From page 4 of PTSD but the comprehensive plan of care did not include PTSD including triggers and trauma informed care. R10's quarterly MDS assessment dated 3/2/25, indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, utilized a walker and wheelchair, diagnoses included non-traumatic brain dysfunction, anxiety, depression, and post-traumatic stress disorder (PTSD), and antipsychotics were received on a routine basis. R10's care plan dated 5/10/25, indicated cognition: alteration in thought process r/t (related to) dementia in severe loss range, family kept updated and makes decisions on her behalf, family also consulted for history of needs and background information to assist with daily needs provide cues for her to participate with completing ADL (activity of daily living) needs with schedule she is comfortable with and supervision throughout the day to be sure any independent decisions are appropriate, observe for any changes with cognition or level of alertness and report if; activities: alteration in lifestyle r/t dementia in severe loss range, anxiety, chronic disease process, new environment needs assistance to, from and during activities of her preferences, shows signs of increased agitation, wanting to go home having things to do with difficulty in redirection, needs staff assistance to divert energy and attention to validate feelings, staff will encourage and assist to, from and during activities of her preference, in attempts to ward off onset of agitation, provide meaningful 1:1 visits of conversations, attempts at reminiscing, picture books, sensory, validate feelings to resident when she is agitated and attempt to find quiet, calming activities with safe items or	F 656			

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F 656	Continued From page 5 materials. R10's care plan failed to indicate PTSD triggers and interventions. On 5/12/25 at 3:43 p.m., during a telephone interview family member (FM)-D stated R10 had a history of PTSD. On 5/13/25 at 8:51 a.m., NA-G stated she was uncertain if R10 had a history of trauma or PTSD and would need to look in R10's chart. NA-G stated, "maybe the nurse would know". On 5/13/25 at 9:48 a.m., RN-B stated she was verbally informed of R10's PTSD history. RN-B stated the care plan was expected to include R10's PTSD and confirmed R10's care plan did not include or identify PTSD triggers or interventions. On 5/13/25 at 10:26 a.m. NA-H stated she was aware R10 had a history of PTSD, but was unsure of specific triggers and stated she would expect the triggers indicated on the care plan. NA-H stated she used the care plan located in the paper chart. NA-H was observed and looked at R10's paper chart and confirmed R10's record did not identify PTSD triggers or interventions. NA-H stated she was uncertain where to find R10's PTSD related information. On 5/13/25 at 12:06 p.m., during an interview with the DON and social services (SS)-A the DON confirmed R10's care plan did not include information related to PTSD as expected. Facility Trauma Informed Care policy dated 8/24, indicated :	F 656			

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F 656	Continued From page 6 Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. Facility Interdisciplinary Resident Care Plan policy dated 5/22, indicated: 1. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal Representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 3. Assessment of residents are ongoing and care plans are revised as information about The residents and the residents' condition change. 4. The resident care plan is reviewed every 90 days by all member of the Interdisciplinary team. 5. Changes are made as needed on the care plan by all team members. 6. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate is encouraged to participate in the development of and revisions of the resident's care plan.	F 656			

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F 684 F 684 SS=D	Continued From page 7 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of measured weights for 1 of 1 resident (R29) reviewed for nutrition. Findings include: R29's face sheet printed on 5/14/25, included diagnoses of diabetes, high blood pressure, and history of stroke. R29's quarterly Minimum Data Set (MDS) assessment dated 3/16/25, indicated severe cognitive impairment, clear speech, could understand and be understood. No weight loss and no difficulty swallowing. R29 required substantial assistance or was dependent upon staff for activities of daily living. R29's physician orders dated 12/12/23, indicated regular diet. R29 was not on a diuretic (a medication that increases urine output). R29's care plan dated 3/26/25, indicated R29 had an altered nutritional status related to diabetes			F 684 F 684	R29 weights were reviewed and corrected. All residents have potential to be affected. Will audit weights of all residents for past three months for inaccuracies. Reviewed and updated Weight Monitoring Policy to include obtaining weight procedures. Nursing staff training on weight charting, how to check prior weight and obtaining weights/use of scales. Competency of all nursing staff on obtaining weights and charting of weights to be completed by 7/3/25. Updated orientation of nursing staff to include obtaining and charting of weights competency. Added to ETAR for charge nurse to review weight. Weights and weight variance report will be reviewed weely at IDT meetings for discrepancies and inaccuracies. QAPI committee will monitor and make further recommendations. Director of nursing/designee will monitor overall compliance.		7/3/25

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F 684	Continued From page 8 and history of stroke. A goal for R29 dated 3/15/24, indicated R29 would have stable weights by estimated date of 6/24/25. Intervention dated 12/18/23, indicated to monitor weight and intake. (The frequency was not defined). Intervention dated 3/26/25, indicated R29 was independent with eating after meal set up and staff would encourage and assist. Nursing progress note dated 3/7/25, indicated family member (FM)-A was concerned about R29's eating; stated R29 ate slower and was easily distracted. Dietician progress note dated 3/24/25, indicated: 8# (pound) weight gain in past 6 months. Not significant. Continued regular diet, ate 50-75% for breakfast, and 75-100% of lunch and dinner. No chewing or swallowing difficulties. Cognitive status decreased further this quarter. Will continue to monitor intakes, weights, dehydration and nutrition risk. Continue with care plan. During record review noted potential discrepancies in measured weights. Twenty-two weights were reviewed for six months, from 11/5/24, through 5/6/25. Three incidences appeared potentially inaccurate: 12/17/24: 134# (pounds) 12/31/24: 142# (increase of 8#) 1/7/25: 135 # (decrease of 7#) 2/25/25: 148# 3/4/25: 129# (decrease of 19#) 3/7/25: 130# 3/11/25: 142# (increase of 12#) 3/18/25: 132# (decrease of 10#)	F 684			

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F 684	Continued From page 9 During an interview on 5/13/25 at 8:52 a.m., nursing assistant (NA)-A stated residents were weighed on their bath day. While standing in the tub room on first floor, NA-A demonstrated how residents were weighed using the chair in the tub that slid out and onto an Apollo Mobile Digital Scale. NA-A stated staff pressed the ON/ZERO button which displayed the residents weight. NA-A stated NA's recorded the weight in the electronic medical record (EMR). When entering a new weight, NA-A stated they did not see the previous weight, would need to go to a different part of the EMR. During an interview on 5/13/25 at 3:57 p.m., R29's weights for the past six months were reviewed with the director of nursing (DON). The DON acknowledged they were likely inaccurate. The DON stated she had posted the Apollo Mobile Digital Scale Operations instructions in the nurses station on first floor for staff reference. The instructions indicated how to operate the scale. The DON provided a copy of the instructions which were page 51 of the operations manual dated November 2017. The DON stated if staff didn't zero out the scale, the reading of the weight could be inaccurate. Further, the DON stated the resident could not have their feet on the foot rests of scale or on the floor - they had to hold them off the floor to get an accurate weight. While the instructions indicated the residents feet could not be on the foot rests, it did not indicate the feet had to be off the floor. The DON stated NA's had not received formal training on the use of the scale and no competency had been conducted to ensure NA's knew how to use it properly. Further, the DON stated there was no auto-alert in the EMR when staff recorded a	F 684			

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F 684	Continued From page 10 weight significantly higher or lower than the last recorded weight. The DON stated she would expect licensed nursing staff to be aware of weight fluctuations and to follow-up on them. During an interview on 5/14/25 at 7:31 a.m., licensed practical nurse (LPN)-A stated she was aware NA's had been having problems with the scale. LPN-A stated if she noted significant weight fluctuations, she would ask the NA to re-weigh the resident. LPN-A stated R29 had been having some issues eating - not remembering how to feed herself, and that it took her a long time to eat. LPN-A stated staff had started taking her to the dining room earlier, so she had more time to eat, and staff sat next to her to encourage and/or feed her. LPN-A looked in the EMR and verified the significant weight fluctuations and did not believe them to be accurate. LPN-A stated the EMR did not provide an auto-alert to indicate when a residents weight was significantly different from the previous weight so it could go unnoticed. During an interview on 5/14/25 at 8:12 a.m., NA-C stated she had training on the Apollo scale when she was hired and knew a residents feet had to be off the foot rests of the scale and off the floor. NA-C stated they did not have to zero out the scale, just turn it on and it was ready to go. NA-C stated NA's entered the weight into the EMR but could not see the previous weight. During an interview on 5/14/25 at 9:02 a.m., NA-D stated she fed R29 breakfast and R29 ate everything. With NA-D and NA-C together, NA-C stated R29 could eat snacks in her room independently that her family brought in but was not able to feed herself with a fork -- she mainly	F 684			

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F 684	Continued From page 11 played with her food and stacked cups on her plate. Registered nurse (RN)-A provided copies of orientation checklists for NA-A (dated 8/9/24), NA-B (dated 1/17/25), NA-C (dated 12/23/23). The checklists did not include orientation to the Apollo mobile digital scale. For NA-D, RN-A provided a competency checklist from 2019-2020 which include how to weigh a resident accurately (balance the scale, feet off the floor). Facility Weight Monitoring policy dated 3/24/23, indicated weight could be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. A weight monitoring schedule would be developed upon admission for all residents. Newly admitted residents - monitor weight weekly for 4 weeks. Residents with weight loss - monitor weight weekly. If clinically indicated - monitor weight daily. All others - monitor weight monthly.	F 684			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695			7/3/25

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F 695	Continued From page 12 Based on observation, interview, and document review the facility failed to ensure staff were following manufacturer's guidelines with continuous positive airway pressure (CPAP) machine with daily maintenance and weekly cleaning for 1 of 1 resident (R23) reviewed for respiratory care and treatments. Findings include: R23's face sheet printed 5/14/25, included diagnoses of Parkinson's disease (progressive neurodegenerative disorder that affects movement), and obstructive sleep apnea (breathing repeatedly stops or become significantly reduced during sleep often due to collapse of the upper airway). R23's annual Minimum Data Set (MDS) assessment dated 3/2/25, indicated R23 had moderate cognitive impairment, and required moderate assist to stand, toileting substantial to maximal assist of 1 and was able to walk 150 feet with touching and standby by assist. Special treatments included CPAP. R23's plan of care dated 3/11/24, did not include a respiratory plan of care or the use of a CPAP machine. R23's physician orders dated 1/24/25, included rinse CPAP mask and hose with gentle soap and water. Hang to dry, weekly on Friday's at noon. An order dated 2/29/24, included CPAP at bedtime. ResMed AirSense manual, undated, included empty the humidifier tub daily and wipe it thoroughly with a clean disposable cloth and allow			F 695	R23s ETAR updated to include empty of CPAP reservoir and wiping mask. Education on cleaning of CPAP. Reviewed all residents with CPAP/bipap to ensure that cleaning, wiping of mask and emptying of reservoir is on ETAR. Reviewed and updated CPAP/BIPAP cleaning policy. All nursing staff training on CPAP/BIPAP cleaning. Random audits will be completed weekly x 4 weeks and findings will be reported to QAPI committee for further recommendations. Director of Nursing/designee will monitor overall compliance.		

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F 695	Continued From page 13 to dry out of direct sunlight. Weekly included clean the humidifier tub, air tubing and outlet connector in warm water using household dishwashing liquid or wash the humidifier tub and outlet connector in a solution of 1 part vinegar and 9 parts water. Rinse each component thoroughly in water and allow to dry out of direct sunlight or heat. Wipe the exterior of the device with a dry cloth. During an observation and interview on 5/12/25 at 3:52 p.m., R23's Phillips ResMed CPAP machine was on his bedside table, with the mask and tubing hooked around grab bar on his bed still hooked to the machine. A gallon jug of distilled water was present on bedside table. The water reservoir was 1/4 full of water. R23 stated staff don't ever clean the CPAP machine, face mask, tubing or empty out the water when he removes the CPAP mask in the mornings. R23 stated he has the So Clean machine, (on bedside table) but has never seen staff use it. On observation 5/13/25 at 1:38 p.m., water reservoir of CPAP machine was approximately 1/4 full of water. Tubing and mask was hooked around grab bar on bed. On interview 5/13/25 at 12:59 p.m., nursing assistant (NA)-E stated day shift staff don't do anything with the CPAP machine. That would be the night shift. On interview 5/13/25 at 1:07 p.m., NA-F stated she has never cleaned the mask or tubing for R23's CPAP machine and she has never emptied out the CPAP reservoirs. NA-F stated that is generally the night shift who does that.	F 695			

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F 695	Continued From page 14 On interview 5/14/25 at 8:40 a.m., NA-G stated day shift does not do anything with R23's CPAP machine, mask or hose. NA-G stated she is unsure what night shift does. On interview and observation 5/14/25 at 9:11 a.m., R23 stated staff have never cleaned his machine since he has been at facility. R23 stated he has the So Clean machine (device to clean CPAP masks and hoses that kills 99.9% of microorganisms) on his bedside but staff haven't used it since he brought it here. R23 stated he has never seen staff disconnect the tubing and mask and wash it with soap and water. R23 stated staff never empty the water out of the machine and just fill it up when it needs more water. Mask and tubing were hooked onto the grab rail of the bed. On interview and observation 5/14/25 at 9:43 a.m., registered nurse (RN)-C stated she hasn't actually done anything with R23's CPAP machine and added the NA's would empty the water reservoir and clean the mask and tubing per orders. RN-C confirmed there was water in the reservoir and likely wasn't emptied this morning. RN-C stated she is unsure how the So Clean machine works. On interview 5/14/25 at 10:25 a.m., the director of nursing (DON) stated she would expect staff to use the So Clean machine weekly to clean the tubing and mask and added she wasn't aware staff were not using the machine. The DON stated she would expect whoever takes the mask off and turns off the machine would empty the water reservoir after each use. Facility CPAP-BIPAP cleaning policy dated 5/2025			F 695			

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F 695	Continued From page 15 included: - It is the policy of this facility to clean CPAP/BIPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent eh occurrence or spread of infection. -CPAP/BIPAP equipment may vary by manufacturer. Common equipment includes the machine, tubing, mask, headgear/straps, disposable/non-disposable filters, and humidifier chamber. -Respiratory therapy equipment can become colonized with infectious organisms and serve as a source of respiratory infections. -Staff shall perform hand hygiene and wear gloves whenever touching the CPAP/BIPAP equipment. -Dust the machine when needed, and wipe clean with a damp cloth and mild detergent. -If humidification is required, distilled or sterile water will be used to fill the humidifier chamber. Empty the chamber completely after each use and wipe dry. -Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. -Weekly cleaning activities (specify day of week): Wash headgear/straps in warm, soapy water and air dry. Wash tubing with warm, soapy water and air dry.	F 695			
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699			7/3/25

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F 699	Continued From page 16 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to identify and document the trauma-related history, post-traumatic stress disorder (PTSD), known triggers and lacked a system or process for completing trauma assessments for 2 of 2 residents (R10 and R23) with a known history of PTSD. Findings include: R23's face sheet printed 5/14/25, included diagnoses of Parkinson's disease (progressive neurodegenerative disorder that affects movement), psychological trauma, dementia, and major depressive disorder. R23's annual Minimum Data Set (MDS) dated 3/2/25, indicated R23 had moderate cognitive impairment, no behaviors and required moderate assist to stand, toileting substantial to maximal assist of 1 and was able to walk 150 feet with touching and standby by assist. PTSD was not checked as an active diagnosis. Medications included antipsychotic and antidepressant use. R23's plan of care dated 8/6/24, included a potential for mood deficit related to dementia, Parkinson's disease, depression and anxiety. Interventions included keep resident and family updated, encourage participation in activities of interest, support visits for mood and adjustment, mental health provider visits routinely, allow	F 699	Trauma informed care screening was completed on 5/13/25 for R10 and R23 and care plans updated. Audits of all residents for trauma informed screening to be completed by 7/3/25. Updated and reviewed trauma informed care policy and revised trauma informed care screening form. Screening of all new residents will be completed by LSW. Training of all staff on trauma informed care at all staff meetings 6/9/25 and 6/11/25. Audits of all new admissions charts for trauma informed care to be completed x 3 months. Results will be reviewed by QAPI committee for further recommendations. Director of Nursing/designee will monitor overall compliance.		

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F 699	Continued From page 17 resident to verbalize and express his feelings and frustrations. Medicate with Pristiq (antidepressant), Seroquel (antipsychotic), Remeron (antidepressant), Wellbutrin (antidepressant), Effexor (antidepressant, antianxiety), testosterone injection, olanzapine (antipsychotic) and melatonin (hormone that plays a role in sleep) per MD orders. The plan of care did not include trauma informed care or interventions. R23's document review failed to include a trauma assessment or evaluation of R23's PTSD. On interview 5/13/25 at 12:06 p.m., the director of nursing (DON) confirmed she was aware of R23's history of PTSD. DON confirmed R23's plan of care lacked comprehensive trauma assessment and plan of care for triggers and trauma informed care. On interview 5/13/25 at 12:51 p.m., registered nurse RN-C stated she was not aware of R23's history of trauma. RN-C stated R23 has a lot of anxiety and does not like being at the facility. RN-C not aware of any triggers and confirmed there is no plan of care for PTSD. On interview 5/13/25 at 12:59 p.m., nursing assistant (NE)-E stated she was aware of R23's history of PTSD but was not aware of triggers. NA-E stated she felt R23 had more anxiousness than PTSD and when he is anxious she goes and gets the nurse. On interview, 5/13/25 at 1:07 p.m., NA-F stated she was not aware of R23's history of PTSD but is aware he has a lot of anxiousness. NA-F could not state what triggers R23's PTSD or periods of	F 699			

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F 699	Continued From page 18 anxiousness. NA-F stated we try to distract him by taking him outside or to an activity or we go get the nurse. On interview and observation on 5/14/25 at 9:11 a.m., R23 was sitting in his chair in his room watching television. R23 stated he was in the military but doesn't feel he has PTSD. On interview 5/14/25 at 9:54 a.m., the DON stated during conversations, R23 has said he was shot at and people around him were killed when he was in Vietnam. The DON stated on memorial day during the last program at the facility, R23 was emotional and crying. The DON stated R23 likely didn't want to talk about his history when he stated he doesn't have PTSD. R10's quarterly MDS assessment dated 3/2/25, indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, utilized a walker and wheelchair, diagnoses included non-traumatic brain dysfunction, anxiety, depression, and post-traumatic stress disorder (PTSD), and antipsychotics were received on a routine basis. R10's care plan dated 5/10/25, indicated cognition: alteration in thought process r/t (related to) dementia in severe loss range, family kept updated and makes decisions on her behalf, family, provide cues for her to participate with completing ADL (activity of daily living) needs with schedule she is comfortable with and supervision throughout the day to be sure any independent decisions are appropriate, observe for any changes with cognition or level of alertness and report if; activities: alteration in lifestyle r/t dementia in severe loss range, anxiety, chronic disease process, new environment needs			F 699			

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F 699	Continued From page 19 assistance to, from and during activities of her preferences, shows signs of increased agitation, wanting to go home having things to do with difficulty in redirection, needs staff assistance to divert energy and attention to validate feelings, staff will encourage and assist to, from and during activities of her preference, in attempts to ward off onset of agitation, provide meaningful 1:1 visits of conversations, attempts at reminiscing, picture books, sensory, validate feelings to resident when she is agitated and attempt to find quiet, calming activities with safe items or materials. R10's document review failed to include a trauma assessment or evaluation of R10's PTSD. On 5/12/25 at 3:43 p.m., during a telephone interview family member (FM)-D stated R10 had a history of PTSD. On 5/12/25 at 6:15 p.m., R10 was observed seated in a wheelchair in the day area and completing a puzzle. On 5/13/25 at 8:07 a.m., R10 was seated in a wheelchair in the day area and was completing a puzzle. On 5/13/25 at 8:51 a.m., NA-G stated she was uncertain if R10 had a history of trauma or PTSD and would need to look in R10's chart. NA-G stated, "maybe the nurse would know". NA-G stated education was not provided on R10's PTSD triggers or interventions and stated she utilized interventions for dementia and agitation which included distraction, puzzles, coloring and talking about family.			F 699			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/14/2025
NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087		
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F 699	Continued From page 20 On 5/13/25 at 9:48 a.m., RN-B stated she was verbally informed of R10's PTSD history. RN-B stated the care plan was expected to include R10's PTSD and confirmed R10's care plan did not include or identify PTSD triggers or interventions. RN-B stated she was not aware of trauma assessments completed for residents at the facility. On 5/13/25 at 10:26 a.m., NA-H stated she was aware R10 had a history of PTSD, but was unsure of specific triggers and stated she would expect the triggers indicated on the care plan. NA-H stated she used the care plan located in the paper chart. NA-H was observed and looked at R10's paper chart and confirmed R10's record did not identify PTSD triggers or interventions. NA-H stated she was uncertain where to find R10's PTSD related information. On 5/13/25 at 12:06 p.m., during an interview with the DON and social services (SS)-A, the DON confirmed awareness of the R10's PTSD and stated a trauma assessment was not done as expected. The DON and SS-A stated a trauma assessment was important to identify triggers and interventions and include that information on the care plan. The DON and SS-A confirmed there was no current process in place to for identifying or addressing trauma related needs including trauma related triggers and interventions. Facility Trauma Informed Care policy dated 8/24 included: - The facility will use a multi-disciplinary approach to identifying a resident ' s history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a	F 699			

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F 699	Continued From page 21 previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others. - St John ' s will collaborate with resident trauma survivors, and as appropriate, the resident ' s family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. - In some cases, if the facility has more than one trauma survivor, social services will make a good faith effort at establishing a support group that is run by a qualified professional, or allow a support group to meet in the facility. If a group cannot be run/meet at facility, social services will assist the resident in locating a support group in the community as appropriate and feasible. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident ' s exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident ' s care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright/flashing lights. c. Certain sights, such as objects that are associated with their abuser. d. Sounds, smells, and physical touch. -Trauma-specific care plan interventions will recognize the interrelation between trauma and	F 699			

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F 699	Continued From page 22 symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. -The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. - In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.	F 699			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			7/3/25

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F 880	Continued From page 23 §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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880			

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F 880	Continued From page 24 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to ensure proper infection prevention practices was observed when transporting soiled linen when staff were observed to transport soiled linen unbagged and ungloved throughout the River Haven unit hallway. This had the potential to impact all 11 residents residing in the unit. Finding include: R35's quarterly Minimum Data Set (MDS) assessment dated 4/13/25, indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, lower body dressing, and toileting hygiene and diagnoses included non-traumatic brain dysfunction and non-Alzheimer's dementia. R35's care plan dated 5/14/25, indicated ADL's (activity of daily living: alteration in self care r/t (related to) dementia, Parkinson's, poor balance, falls, weak with exertion, chronic disease process, arthritic changes substantial max to partial moderate assist with personal hygiene partial to moderate assist with dressing upper extremities and substantial max to dependent	F 880	All staff educated on proper handling of soiled linen and standard precautions. All residents have the potential to be affected. Developed handling of soiled linen policy to ensure all linen will bagged at bedside or point of use. Training and education of all staff on handling of soiled linen procedures at all staff meetings 6/9/25 and 6/11/25. Random audits of compliance will be completed 3x/wk x 2 weeks, 2x/week x 2 weeks, weekly x 4 weeks. Results will be reviewed by QAPI committee for further recommendations. Director of Nursing or designee will monitor overall compliance.		

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F 880	Continued From page 25 with lower extremities and footwear. On 5/13/25 8:15 a.m., nursing assistant (NA)-G exited R35's room and was observed carrying linen in her bare hands without placing the linen in a bag and without wearing gloves. NA-G proceeded through the hallway ungloved while carrying the unbagged linen and entered the tub room. In the tub room NA-G unwrapped the linen with her bare hands, revealing a brief mixed with the linens. NA-G separated the brief from the linen using her bare hands and placed the linen into the soiled linen hamper and the brief into a trash receptacle. NA-G stated she was not sure if the linen needed to be bagged when carried throughout the hallways and confirmed she did not wear gloves in the hallway while carrying the soiled linen. NA-G stated gloves were not allowed worn in the hallways. NA-G stated that the brief had been worn by the resident but was not visibly soiled with urine or feces and acknowledged the clothing was also worn. NA-G was observed washing her hands with soap and water for 21 seconds. During an interview on 5/13/25 at 1:11 p.m., on first floor, NA-A stated staff carried soiled laundry, including resident clothing, bed linens and towels, from resident rooms by hand, down the hallway to a hamper in the tub room if it was soiled resident clothing, or the utility room if it was soiled bed linens or towels. NA-A stated she would do this even if there were a small amount of BM (bowel movement) on the laundry. NA-A stated staff did not place soiled laundry in bags first before carrying it to the hampers. NA-A stated she was careful not to let soiled laundry touch her uniform. Further, NA-A stated she had done that as long as she had worked at the facility. Review of NA-A's orientation checklist dated 8/9/24, did not	F 880			

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F 880	Continued From page 26 include instruction on transporting soiled laundry. During an interview on 5/13/25 at 1:29 p.m., on second floor, NA-F stated soiled laundry was carried by hand to either the utility room or tub room, such as resident clothing, towels, washcloths and bed linen. NA-F stated soiled laundry was not placed in a bag first before carrying it to the hampers. NA-F stated if something was heavily soiled and if there were extra bags in the residents wastebasket, she would place the soiled items in the bag. NA-F stated she was careful not to let the soiled items touch her uniform. During an interview on 5/13/25 at 2:45 p.m., registered nurse (RN)-A, who was also the infection preventionist, stated staff were to transport soiled laundry from resident rooms to the utility room or tub room hampers in a bag and away from their uniform. RN-A was informed of observation and interviews. During an interview on 5/14/25 at 12:29 p.m., the director of nursing (DON) was informed of observation and interviews regarding nursing staff carrying soiled laundry by hand, from resident rooms to the tub room or utility room to place in hampers. The DON stated staff could take the hampers to the resident rooms instead of carrying the laundry to the hampers. The DON acknowledged that still had the potential for staff to carry soiled items a distance. The DON stated if they (staff) did not do that, she would expect them to place soiled laundry in bags to carry to the hampers. The DON could not recall if nursing staff had received training on the expected way to transfer soiled laundry.	F 880			

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F 880	Continued From page 27 Facility Infection Prevention and Control Program policy dated 2/2025, indicated the facility had established and maintained 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 as per accepted national standards and guidelines. Direct care staff would handle, store, process, and transport linens to prevent spread of infection. Soiled linen would be collected at the bedside and placed in a linen bag. When the task was complete, the bag would be closed securely and placed in the soiled utility room.	F 880			
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the kitchen ceiling tiles were kept in a clean and sanitary manner and free of dust and debris. This had the potential to affect all 46 residents residing in the facility. Findings include: On 5/13/25 at 9:08 a.m., two ceiling tiles located approximately six feet from the steam table were observed with gray, fuzzy material hanging from them. Directly beneath these ceiling tiles were two metal meal carts. At the time of observation, cook (C)-A was interviewed and confirmed the	F 921	1. Immediate Corrective Action: The Cleaning and Sanitation of Dining and Food Service Areas policy has been reviewed and updated as necessary. All dietary staff were re-educated on the revised policy and procedure to ensure full compliance with cleaning standards. 2. Systemic Changes to Prevent Recurrence: Staff have been re-trained on the appropriate frequency and method of cleaning dining and food service areas, specifically the ceiling tiles above the food preparation and tray assembly areas.		6/13/25

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F 921	Continued From page 28 presence of the gray fuzzy material on the ceiling tiles, acknowledging the condition was unclean and unacceptable. C-A stated that kitchen staff were responsible for cleaning the ceiling tiles and further confirmed that plated food trays were placed on the metal carts located under the affected ceiling area before being delivered to residents. On 5/13/25 at 10:45 a.m., dietary aide (DA)-A was observed placing plated food onto meal trays located on metal carts situated directly beneath the ceiling tiles with visible gray material. On 5/13/25 at 11:09 a.m., maintenance director (MD)-A stated the kitchen staff were responsible to clean the kitchen ceiling tiles. On 5/13/25 at 12:17 p.m., the dietary director (DD)-C confirmed that the ceiling tiles were not included on the routine cleaning checklist. DD-C stated ceiling tiles above food preparation and tray assembly areas were expected to be clean and free of debris and would expect maintenance to clean the tiles when dirty. DD-C provided the kitchen cleaning schedule, which did not include ceiling tile cleaning. On 5/14/25 at 10:15 a.m., the administrator stated that kitchen ceiling tiles were expected to remain clean and free from debris. The administrator further stated that when debris is observed, both kitchen staff and maintenance are expected to coordinate to ensure cleanliness of the ceiling tiles.. Facility Cleaning and Sanitation of Dining and Food Service Area policy dated 2017, indicated:	F 921	The Dietary Manager will conduct routine environmental audits to verify ongoing compliance and preventive maintenance tasks are being carried out. When deep cleaning is required beyond regular duties, the Dietary Manager will coordinate with Plant Operations to ensure completion. 3. Monitoring and Quality Assurance: The QAPI Committee will review this issue during monthly meetings. The Dietary Manager will report audit findings and corrective actions taken at each QAPI meeting to monitor for continued compliance and identify any trends.		

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F 921	Continued From page 29 The nutrition and food services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. The director of food and nutrition services will determine all cleaning and sanitation task needed for the departments. Staff will be trained on frequency of cleaning as necessary.	F 921			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/14/2025. At the time of this survey, St. John 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. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. John Lutheran Home The facility has a capacity of 55 beds and had a census of 46 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K 000			

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K 291 K 291 SS=F	Continued From page 2 Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 at at 9:33 AM , it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested annually for 90 minutes within the last year. This deficient finding was confirmed by the Plant Operations Director at the time of discovery.	K 291 K 291			6/6/25
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324			5/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
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K 324	Continued From page 3 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * 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 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3, and NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/14/2025 at 10:12 AM, it was revealed during documentation review that the facility could not provide documentation that the range hood suppression system was being inspected every 6	K 324	Hood Suppression System Checks: Testing and documentation follow-up have been incorporated into the TELS App for the February and August hood suppression inspections. Documentation for the February 2025 hood inspection was submitted the following of Fire Marshal visit. Plant Operations will ensure proper documentation is submitted after each scheduled check moving forward.		

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

PRINTED: 06/11/2025
FORM APPROVED
OMB NO. 0938-0391

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K 324	Continued From page 4 months. 2. On 05/14/2025 at 10:53 AM, it was revealed by observation that the residential stove located on the first floor does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. 3. On 05/14/2025 at 11:17 AM, it was revealed by observation that the residential stove located on the second floor does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action.	K 324			
K 345 SS=F	These deficient findings were confirmed by the Plant Operations Director and Administrator at the time of discovery. Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain	K 345		6/6/25	
			K345: Fire Alarm System Testing and Maintenance		

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K 345	Continued From page 5 the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 at 11:42 AM, it was revealed by a review of available documentation and observation that the deficiencies listed below were noted on the annual fire alarm inspection report dated 08/22/24 and at the time of the survey the facility did not have documentation showing that repairs had been made. - Replace pull station by dining room nurse's station This deficient finding was confirmed by the Plant Operations Director and Administrator at the time of discovery..	K 345	Plant Operations has ordered a replacement pull station for the unit located at the 1SW Nurses Station through Brothers Fire.		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		6/13/25	

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K 353	Continued From page 6 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3, 4.4, 4.7 and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 26.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/14/2025 at 9:45, it was revealed by a review of available documentation that the facility could not provide current documentation for a annual sprinkler inspection. 2. On 05/14/2025 at 9:45, it was revealed by a review of available documentation that the facility could not provide documentation for quarterly sprinkler inspections for the 4th quarter of 2024. These deficient findings were confirmed by the Plant Operations Director at the time of discovery.	K 353	K353: Sprinkler System Maintenance and Testing Plant Operations has contacted Brothers Fire to ensure quarterly testing and annual inspections of the sprinkler system are completed on schedule, in compliance with State Fire Marshal requirements. A corresponding reminder and documentation note has also been added to the TELS App to support timely completion and recordkeeping.		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101	K 363		5/30/25	

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K 363	Continued From page 7 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 363			

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K 363	Continued From page 8 Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. These deficient findings could have a isolated impact on the residents within the facility. Findings include: 1. On 05/14/2025 at 10:45 AM, it was revealed by observation that the door to resident room 1 would not latch. 2. On 05/14/2025 at 11:35 AM, it was revealed by observation that the door to resident room 137 would not latch. These deficient findings were confirmed by the Plant Operations Director and Administrator at the time of discovery.			K 363	K363: Corridor Doors Riverhaven Room #1: Plant Operations has confirmed that the door handle was replaced, and it now latches properly when closed. Riverhaven Room #137: Plant Operations has confirmed that the door handle was replaced, and it now latches properly when closed.		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by:			K 711			6/4/25

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K 711	Continued From page 9 Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 at 10:27 AM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include transmission of alarms to fire department. This deficient finding was confirmed by the Plant Operations Director at the time of discovery.	K 711	The fire plan and procedure have been revised to include that the facility's alarm system is connected to the fire department.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 27, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: TWNB11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/14/2025
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/12/25 through 5/14/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT IN compliance with the MN State Licensure and the following correction orders are issued.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/05/25

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was reviewed: H54073888C (MN106529). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000			

Minnesota Department of Health

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2 000	Continued From page 2 enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in	2 302			6/27/25

Minnesota Department of Health

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2 302	Continued From page 3 written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in written or electronic format, a description of the the facilities Alzheimer's training program, the categories of staff trained, the basic topics covered and the frequency of the training. Findings include: Review of the facility Matrix provided 5/12/25, identified twenty residents with Alzheimer's dementia. On interview on 5/13/25 at 3:05 p.m., the administrator confirmed the facility had not provided to consumers in written or electronic form, a description of the Alzheimer's Disease or related training program, the categories of employees trained, the frequency of training, and the basic topics covered. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the	2 302	Corrected		

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2 302	Continued From page 4 related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, DON, or designee could develop a system to ensure training is available as required to residents, families and others who request it. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed and implemented to include of post-traumatic stress disorder (PTSD) triggers and interventions for 2 of 2 residents (R10 and R23) who had a diagnosis of PTSD. Findings include: R23's face sheet printed 5/14/25, included diagnoses of Parkinson's disease (progressive neurodegenerative disorder that affects	2 565	corrected		7/3/25

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2 565	Continued From page 5 movement), psychological trauma, dementia, and major depressive disorder. R23's annual Minimum Data Set (MDS) dated 3/2/25, indicated R23 had moderate cognitive impairment, no behaviors and required moderate assist to stand, toileting substantial to maximal assist of 1 and was able to walk 150 feet with touching and standby by assist. PTSD was not checked as an active diagnosis. Medications included antipsychotic and antidepressant use. R23's plan of care dated 8/6/24, included a potential for mood deficit related to dementia, Parkinson's disease, depression and anxiety. Interventions included keep resident and family updated, encourage participation in activities of interest, support visits for mood and adjustment, mental health provider visits routinely, allow resident to verbalize and express feelings and frustrations. Medicate with Pristiq (antidepressant), Seroquel (antipsychotic), Remeron (antidepressant), Wellbutrin (antidepressant), Effexor (antidepressant, antianxiety), testosterone injection, olanzapine (antipsychotic) and melatonin (hormone that plays a role in sleep) per MD orders. R23's care plan failed to indicate PTSD triggers and interventions. On 5/13/25 at 12:51 p.m., registered nurse RN-C stated she was not aware of R23's history of trauma. RN-C stated R23 has a lot of anxiety and does not like being at the facility. RN-C is not aware of any triggers and confirmed there is no plan of care for PTSD. On 5/13/25 at 12:59 p.m., nursing assistant (NE)-E stated she was aware of R23's history of	2 565			

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2 565	Continued From page 6 PTSD but was not aware of triggers. NA-E stated she felt R23 had more anxiousness than PTSD and when he is anxious she goes and gets the nurse. On 5/13/25 at 1:07 p.m., NA-F stated she was not aware of R23's history of PTSD but is aware he has a lot of anxiousness. NA-F could not state what triggers the PTSD or periods of anxiousness. NA-F stated we try to distract him by taking him outside or to an activity or we go get the nurse. On 5/13/25 at 12:06 p.m., the director of nursing (DON) confirmed she was aware of R23's history of PTSD but the comprehensive plan of care did not include PTSD including triggers and trauma informed care. R10's quarterly MDS assessment dated 3/2/25, indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, utilized a walker and wheelchair, diagnoses included non-traumatic brain dysfunction, anxiety, depression, and post-traumatic stress disorder (PTSD), and antipsychotics were received on a routine basis. R10's care plan dated 5/10/25, indicated cognition: alteration in thought process r/t (related to) dementia in severe loss range, family kept updated and makes decisions on her behalf, family also consulted for history of needs and background information to assist with daily needs provide cues for her to participate with completing ADL (activity of daily living) needs with schedule she is comfortable with and supervision throughout the day to be sure any independent decisions are appropriate, observe for any changes with cognition or level of alertness and	2 565			

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2 565	Continued From page 7 report if; activities: alteration in lifestyle r/t dementia in severe loss range, anxiety, chronic disease process, new environment needs assistance to, from and during activities of her preferences, shows signs of increased agitation, wanting to go home having things to do with difficulty in redirection, needs staff assistance to divert energy and attention to validate feelings, staff will encourage and assist to, from and during activities of her preference, in attempts to ward off onset of agitation, provide meaningful 1:1 visits of conversations, attempts at reminiscing, picture books, sensory, validate feelings to resident when she is agitated and attempt to find quiet, calming activities with safe items or materials. R10's care plan failed to indicate PTSD triggers and interventions. On 5/12/25 at 3:43 p.m., during a telephone interview family member (FM)-D stated R10 had a history of PTSD. On 5/13/25 at 8:51 a.m., NA-G stated she was uncertain if R10 had a history of trauma or PTSD and would need to look in R10's chart. NA-G stated, "maybe the nurse would know". On 5/13/25 at 9:48 a.m., RN-B stated she was verbally informed of R10's PTSD history. RN-B stated the care plan was expected to include R10's PTSD and confirmed R10's care plan did not include or identify PTSD triggers or interventions. On 5/13/25 at 10:26 a.m. NA-H stated she was aware R10 had a history of PTSD, but was unsure of specific triggers and stated she would expect the triggers indicated on the care plan.	2 565			

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2 565	Continued From page 8 NA-H stated she used the care plan located in the paper chart. NA-H was observed and looked at R10's paper chart and confirmed R10's record did not identify PTSD triggers or interventions. NA-H stated she was uncertain where to find R10's PTSD related information. On 5/13/25 at 12:06 p.m., during an interview with the DON and social services (SS)-A the DON confirmed R10's care plan did not include information related to PTSD as expected. Facility Trauma Informed Care policy dated 8/24, indicated : Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. Facility Interdisciplinary Resident Care Plan policy dated 5/22, indicated: 1. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal Representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 3. Assessment of residents are ongoing and care plans are revised as information about The residents and the residents' condition change.	2 565			

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2 565	Continued From page 9 4. The resident care plan is reviewed every 90 days by all member of the Interdisciplinary team. 5. Changes are made as needed on the care plan by all team members. 6. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate is encouraged to participate in the development of and revisions of the resident's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could create and/or review or revise policies and procedures related to developing and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The DON or designee could develop a system to educate staff and develop a monitoring/auditing system to ensure staff are providing care as directed by the plan of care, The audits results could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as	2 875			7/3/25

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2 875	Continued From page 10 indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure accuracy of measured weights for 1 of 1 resident (R29) reviewed for nutrition. Findings include: R29's face sheet printed on 5/14/25, included diagnoses of diabetes, high blood pressure, and history of stroke. R29's quarterly Minimum Data Set (MDS) assessment dated 3/16/25, indicated severe cognitive impairment, clear speech, could understand and be understood. No weight loss and no difficulty swallowing. R29 required substantial assistance or was dependent upon staff for activities of daily living. R29's physician orders dated 12/12/23, indicated regular diet. R29 was not on a diuretic (a medication that increases urine output). R29's care plan dated 3/26/25, indicated R29 had an altered nutritional status related to diabetes and history of stroke. A goal for R29 dated 3/15/24, indicated R29 would have stable weights by estimated date of 6/24/25. Intervention dated 12/18/23, indicated to monitor weight and intake. (The frequency was not defined). Intervention dated 3/26/25, indicated R29 was independent with eating after meal set up and staff would encourage and assist.	2 875	corrected		

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2 875	Continued From page 11 Nursing progress note dated 3/7/25, indicated family member (FM)-A was concerned about R29's eating; stated R29 ate slower and was easily distracted. Dietician progress note dated 3/24/25, indicated: 8# (pound) weight gain in past 6 months. Not significant. Continued regular diet, ate 50-75% for breakfast, and 75-100% of lunch and dinner. No chewing or swallowing difficulties. Cognitive status decreased further this quarter. Will continue to monitor intakes, weights, dehydration and nutrition risk. Continue with care plan. During record review noted potential discrepancies in measured weights. Twenty-two weights were reviewed for six months, from 11/5/24, through 5/6/25. Three incidences appeared potentially inaccurate: 12/17/24: 134# (pounds) 12/31/24: 142# (increase of 8#) 1/7/25: 135 # (decrease of 7#) 2/25/25: 148# 3/4/25: 129# (decrease of 19#) 3/7/25: 130# 3/11/25: 142# (increase of 12#) 3/18/13: 132# (decrease of 10#) During an interview on 5/13/25 at 8:52 a.m., nursing assistant (NA)-A stated residents were weighed on their bath day. While standing in the tub room on first floor, NA-A demonstrated how residents were weighed using the chair in the tub that slid out and onto an Apollo Mobile Digital Scale. NA-A stated staff pressed the ON/ZERO button which displayed the residents weight. NA-A stated NA's recorded the weight in the	2 875			

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2 875	Continued From page 12 electronic medical record (EMR). When entering a new weight, NA-A stated they did not see the previous weight, would need to go to a different part of the EMR. During an interview on 5/13/25 at 3:57 p.m., R29's weights for the past six months were reviewed with the director of nursing (DON). The DON acknowledged they were likely inaccurate. The DON stated she had posted the Apollo Mobile Digital Scale Operations instructions in the nurses station on first floor for staff reference. The instructions indicated how to operate the scale. The DON provided a copy of the instructions which were page 51 of the operations manual dated November 2017. The DON stated if staff didn't zero out the scale, the reading of the weight could be inaccurate. Further, the DON stated the resident could not have their feet on the foot rests of scale or on the floor - they had to hold them off the floor to get an accurate weight. While the instructions indicated the residents feet could not be on the foot rests, it did not indicate the feet had to be off the floor. The DON stated NA's had not received formal training on the use of the scale and no competency had been conducted to ensure NA's knew how to use it properly. Further, the DON stated there was no auto-alert in the EMR when staff recorded a weight significantly higher or lower than the last recorded weight. The DON stated she would expect licensed nursing staff to be aware of weight fluctuations and to follow-up on them. During an interview on 5/14/25 at 7:31 a.m., licensed practical nurse (LPN)-A stated she was aware NA's had been having problems with the scale. LPN-A stated if she noted significant weight fluctuations, she would ask the NA to re-weigh the resident. LPN-A stated R29 had	2 875			

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2 875	Continued From page 13 been having some issues eating - not remembering how to feed herself, and that it took her a long time to eat. LPN-A stated staff had started taking her to the dining room earlier, so she had more time to eat, and staff sat next to her to encourage and/or feed her. LPN-A looked in the EMR and verified the significant weight fluctuations and did not believe them to be accurate. LPN-A stated the EMR did not provide an auto-alert to indicate when a residents weight was significantly different from the previous weight so it could go unnoticed. During an interview on 5/14/25 at 8:12 a.m., NA-C stated she had training on the Apollo scale when she was hired and knew a residents feet had to be off the foot rests of the scale and off the floor. NA-C stated they did not have to zero out the scale, just turn it on and it was ready to go. NA-C stated NA's entered the weight into the EMR but could not see the previous weight. During an interview on 5/14/25 at 9:02 a.m., NA-D stated she fed R29 breakfast and R29 ate everything. With NA-D and NA-C together, NA-C stated R29 could eat snacks in her room independently that her family brought in but was not able to feed herself with a fork -- she mainly played with her food and stacked cups on her plate. Registered nurse (RN)-A provided copies of orientation checklists for NA-A (dated 8/9/24), NA-B (dated 1/17/25), NA-C (dated 12/23/23). The checklists did not include orientation to the Apollo mobile digital scale. For NA-D, RN-A provided a competency checklist from 2019-2020 which include how to weigh a resident accurately (balance the scale, feet off the floor).	2 875			

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2 875	Continued From page 14 Facility Weight Monitoring policy dated 3/24/23, indicated weight could be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. A weight monitoring schedule would be developed upon admission for all residents. Newly admitted residents - monitor weight weekly for 4 weeks. Residents with weight loss - monitor weight weekly. If clinically indicated - monitor weight daily. All others - monitor weight monthly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review policies and procedures for obtaining accurate weights on residents. The DON or designee could educate staff on the policy and procedure and provide training. The DON or designee could conduct random audits of measured weights to ensure accuracy and investigate inaccuracies. The facility could report findings to the quality assurance performance improvement (QAPI) committee for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875			
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and	21675			7/3/25

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21675	Continued From page 15 include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, and interview the facility failed to ensure proper infection prevention practices was observed when transporting soiled linen when staff were observed to transport soiled linen unbagged and ungloved throughout the River Haven unit hallway. This had the potential to impact all 11 residents residing in the unit. Finding include: R35's quarterly Minimum Data Set (MDS) assessment dated 4/13/25, indicated severe cognitive impairment, required substantial/maximal assistance with personal hygiene, lower body dressing, and toileting hygiene and diagnoses included non-traumatic brain dysfunction and non-Alzheimer's dementia. R35's care plan dated 5/14/25, indicated ADL's (activity of daily living: alteration in self care r/t (related to) dementia, Parkinson's, poor balance, falls, weak with exertion, chronic disease process, arthritic changes substantial max to partial moderate assist with personal hygiene partial to moderate assist with dressing upper extremities and substantial max to dependent with lower extremities and footwear. On 5/13/25 8:15 a.m., nursing assistant (NA)-G exited R35's room and was observed carrying linen in her bare hands without placing the linen in a bag and without wearing gloves. NA-G proceeded through the hallway ungloved while	21675	corrected		

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21675	Continued From page 16 carrying the unbagged linen and entered the tub room. In the tub room NA-G unwrapped the linen with her bare hands, revealing a brief mixed with the linens. NA-G separated the brief from the linen using her bare hands and placed the linen into the soiled linen hamper and the brief into a trash receptacle. NA-G stated she was not sure if the linen needed to be bagged when carried throughout the hallways and confirmed she did not wear gloves in the hallway while carrying the soiled linen. NA-G stated gloves were not allowed worn in the hallways. NA-G stated that the brief had been worn by the resident but was not visibly soiled with urine or feces and acknowledged the clothing was also worn. NA-G was observed washing her hands with soap and water for 21 seconds. During an interview on 5/13/25 at 1:11 p.m., on first floor, NA-A stated staff carried soiled laundry, including resident clothing, bed linens and towels, from resident rooms by hand, down the hallway to a hamper in the tub room if it was soiled resident clothing, or the utility room if it was soiled bed linens or towels. NA-A stated she would do this even if there were a small amount of BM (bowel movement) on the laundry. NA-A stated staff did not place soiled laundry in bags first before carrying it to the hampers. NA-A stated she was careful not to let soiled laundry touch her uniform. Further, NA-A stated she had done that as long as she had worked at the facility. Review of NA-A's orientation checklist dated 8/9/24, did not include instruction on transporting soiled laundry. During an interview on 5/13/25 at 1:29 p.m., on second floor, NA-F stated soiled laundry was carried by hand to either the utility room or tub room, such as resident clothing, towels,	21675			

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NAME OF PROVIDER OR SUPPLIER ST JOHN LUTHERAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
21675	Continued From page 17 washcloths and bed linen. NA-F stated soiled laundry was not placed in a bag first before carrying it to the hampers. NA-F stated if something was heavily soiled and if there were extra bags in the residents wastebasket, she would place the soiled items in the bag. NA-F stated she was careful not to let the soiled items touch her uniform. During an interview on 5/13/25 at 2:45 p.m., registered nurse (RN)-A, who was also the infection preventionist, stated staff were to transport soiled laundry from resident rooms to the utility room or tub room hampers in a bag and away from their uniform. RN-A was informed of observation and interviews. During an interview on 5/14/25 at 12:29 p.m., the director of nursing (DON) was informed of observation and interviews regarding nursing staff carrying soiled laundry by hand, from resident rooms to the tub room or utility room to place in hampers. The DON stated staff could take the hampers to the resident rooms instead of carrying the laundry to the hampers. The DON acknowledged that still had the potential for staff to carry soiled items a distance. The DON stated if they (staff) did not do that, she would expect them to place soiled laundry in bags to carry to the hampers. The DON could not recall if nursing staff had received training on the expected way to transfer soiled laundry. Facility Infection Prevention and Control Program policy dated 2/2025, indicated the facility had established and maintained 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	21675			

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21675	Continued From page 18 infections as per accepted national standards and guidelines. Direct care staff would handle, store, process, and transport linens to prevent spread of infection. Soiled linen would be collected at the bedside and placed in a linen bag. When the task was complete, the bag would be closed securely and placed in the soiled utility room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on soiled linen handling and transport to ensure accuracy; then educate floor staff and audit routinely to ensure ongoing compliance. The audits results could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21675			
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the kitchen ceiling tiles were kept in a clean and sanitary	21685	corrected		6/13/25

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21685	Continued From page 19 manner and free of dust and debris. This had the potential to affect all 46 residents residing in the facility. Findings include: On 5/13/25 at 9:08 a.m., two ceiling tiles located approximately six feet from the steam table were observed with gray, fuzzy material hanging from them. Directly beneath these ceiling tiles were two metal meal carts. At the time of observation, cook (C)-A was interviewed and confirmed the presence of the gray fuzzy material on the ceiling tiles, acknowledging the condition was unclean and unacceptable. C-A stated that kitchen staff were responsible for cleaning the ceiling tiles and further confirmed that plated food trays were placed on the metal carts located under the affected ceiling area before being delivered to residents. On 5/13/25 at 10:45 a.m., dietary aide (DA)-A was observed placing plated food onto meal trays located on metal carts situated directly beneath the ceiling tiles with visible gray material. On 5/13/25 at 11:09 a.m., maintenance director (MD)-A stated the kitchen staff were responsible to clean the kitchen ceiling tiles. On 5/13/25 at 12:17 p.m., the dietary director (DD)-C confirmed that the ceiling tiles were not included on the routine cleaning checklist. DD-C stated ceiling tiles above food preparation and tray assembly areas were expected to be clean and free of debris and would expect maintenance to clean the tiles when dirty. DD-C provided the kitchen cleaning schedule, which did not include ceiling tile cleaning.	21685			

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21685	Continued From page 20 On 5/14/25 at 10:15 a.m., the administrator stated that kitchen ceiling tiles were expected to remain clean and free from debris. The administrator further stated that when debris is observed, both kitchen staff and maintenance are expected to coordinate to ensure cleanliness of the ceiling tiles.. Facility Cleaning and Sanitation of Dining and Food Service Area policy dated 2017, indicated: The nutrition and food services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. The director of food and nutrition services will determine all cleaning and sanitation task needed for the departments. Staff will be trained on frequency of cleaning as necessary. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure cleanliness of kitchen ceilings and and preventative maintenance program developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The administrator, maintenance supervisor, or designee could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The administrator, maintenance supervisor, or designee could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	21685			

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21685	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685			