Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 4, 2025

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: April 9, 2025

Dear Administrator:

On May 20, 2025, the Minnesota Department(s) 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.

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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Electronically delivered
April 28, 2025

Administrator
St Lukes Lutheran Care Center
1219 South Ramsey
Blue Earth, MN 56013

RE: CCN: 245372
Cycle Start Date: April 9, 2025

Dear Administrator:

On April 9, 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 July 9, 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 October 9, 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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES LUTHERAN CARE CENTER	1219 SOUTH RAMSEY BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/7/25 through 4/9/25, 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.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 through 4/9/25, 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: H53722595C (MN001032362) and H53722594C (MN00103873). 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 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2025

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		5/12/25

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed ensure a residents residing in the memory care unit were allowed clothing in a manner to promote dignity when residents were dressed in a hospital gown while participating in activities for 3 of 4 residents (R4, R9, R49) reviewed for dignity. Findings Include: R4's quarterly Minimum Data Set (MDS) assessment dated 2/24/25, indicated R4 had moderately impaired cognition, required moderate assistance with dressing upper body and maximal assistance dressing her lower body and diagnoses of non-Alzheimer's dementia and depression. R4's care plan dated 3/7/25, indicated alterations and potential for further alterations in ADL (activities of daily living) abilities evidenced by history of falls, history TIA, diagnosis of unspecified dementia with behavioral disturbance, and visual impairment. Interventions included extensive assistance of 1-2 to dress, participates by lifting arms and helps to pull shirt on and dependent on staff to put pants on as well as socks and shoes. R9's quarterly MDS assessment dated 2/24/25, indicated R9 had severe cognitive impairment, required maximal assistance with dressing upper body and dependent on staff assistance dressing her lower body and diagnoses of weakness, non-Alzheimer's dementia, anxiety, and	F 550	It is the goal of St. Luke's Lutheran Care Center to provide cares/services for all residents according to their care plan, and in a manner that honors their requests and promotes comfort, dignity, and respect. On 4/8/25, the Director of Nursing posted a staff memo to be read at each shift report through 4/21/25; staff were instructed to sign once read. The staff memo instructed staff not to put residents in their pajamas/gown before supper unless a resident requests or you are instructed to do so by the charge nurse and the resident agrees. When a resident is in their sleep wear before going to bed, staff were instructed to be sure that the resident's body was covered appropriately for dignity and warmth: sweater, pants, and/or lap robe. R9's care plan has been revised to include her request to wear normal clothes rather than a gown while doing activities. R49's care plan has been revised to include a family member's request on her behalf to wear normal clothes rather than a gown during activities. R4's care plan has been updated to include family members' permission for R4 to wear sleep wear to evening activities; R4 states she agrees with this plan. Residents who require assistance with dressing and can communicate their	

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F 550	Continued From page 3 depression R9's care plan dated 2/7/25, indicated alterations in dressing, grooming, and bathing as evidenced by need for assistance and interventions included requires extensive to total assistance of one with daily dressing. R49's quarterly MDS assessment dated 2/24/25, indicated R9 had severe cognitive impairment, required maximal assistance with dressing upper body and dependent on staff assistance dressing her lower body and diagnoses of weakness, non-Alzheimer's dementia. R49's care dated 2/28/25, indicated alteration in ADL's evidenced by need for assistance with all aspects due to weakness and confusion extensive assist of 1-2 to dress, participates by lifting arms and legs with cues, one staff to keep calm or busy or on task while one staff to complete the task as resident is very busy with her hands and grabs at items, tries to sit or stand when not appropriate, etc, will sometimes also help to pull items part way on. On 4/7/25 at 6:00 p.m., R4, R9, R40, R49 were observed in the moonlight wing (locked memory care unit) activity area seated in wheelchairs wearing hospitals gowns, and nine other residents were present. The residents were positioned in a circle and participated in an activity while wearing a hospital style gown, where a ball was kicked around the circle from resident to resident. On 4/7/25 at 6:05 p.m., nursing assistant (NA)-A stated R4, R9, and R49 were assisted with evening cares after their evening meal. NA-A	F 550	preference should be asked when they would like assistance with putting on their sleep wear. For all residents who are unable to state their preference for clothing, the family member/responsible person will be contacted to seek their preference on whether the resident could have sleep wear on in the evening prior to going to bed. Resident care plans will be updated to include this preference. The Director of Nursing reviewed the facility's deficiency and plan of correction with staff at the Nursing Department Meeting held on 4/16/25. On a weekly basis x 1 month and then a monthly basis, the Director of Nursing or her designee will randomly monitor resident cares to ensure compliance with the facility's protocol for resident donning sleep wear prior to going to bed. Results will be used to guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment Performance Improvement (QAPI) Committee Meetings. After 1 year, the QAPI Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 550	Continued From page 4 stated R4, R9, and R49 wore a hospital gown to bed and staff assisted with changing some of the residents into a hospital gown after the evening meal and then the residents were assisted back to the commons area. NA-A stated it was common facility practice that the residents participated in activities in their hospital gown. On 4/7/25 at 6:08 p.m., NA-E stated after the resident's evening meal staff routinely assisted some of the residents with evening cares and assisted resident's into a hospital gown they wore to bed. NA-E stated staff assisting some of the residents with evening cares after the evening meal was more convenient for staff to get the residents into their gown after the evening meal when toileting the residents. NA-E stated a reasonable person would not participate in activities wearing a hospital gown. On 4/7/25 at 6:14 p.m., NA-D and stated staff routinely assisted residents with evening cares after the the evening meal and into the hospital gown they wore to bed, and then the resident's would return to the commons area for activities. NA-D stated assisting some of the residents with bedtime cares after the evening meal helped staff get the residents to bed on time. NA-D stated she had never thought of residents wearing a gown during activities as a dignity concern as they wear the gown to bed. On 4/7/25 at 6:21 p.m., staff were observed and assisted the nine residents with an activity where a large ball was placed in the center of the circle of residents, and the residents kicked the ball around the circle. After that activity residents were assisted the dining room table area for a new activity. R4, R9, R49 were observed in hospital	F 550		

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F 550	Continued From page 5 gowns and seated in their wheelchairs at the dining room table. On 4/7/25 at 6:22 p.m., R9 was seated in a wheelchair in a hospital gown with a blanket over her lap at the dining room table and staff were observed assisting other residents to the dining room for an activity. R9 stated she would rather wear normal clothes then wear the gown she was wearing while doing an activity. On 4/7/25 at 6:23 p.m., R4 and R49 were not able to verbalize if they had concerns wearing a hospital gown while they participated in activities. On 4/7/25 at 6:26 p.m., NA-B stated staff assisted residents to their rooms after the evening meal for toileting and stated some of the residents were provided evening cares at that time that included putting a hospital gown on that they wore to bed. NA-B stated residents who wore a gown to activities were expected to have a blanket on their lap and a sweater cover their top of the body . On 4/8/25 at 9:50 a.m., NA-C stated it was common for residents to wear hospital gowns to evening activities and stated a blanket was expected on the resident's lap and sweater if a hospital gown was worn while residents participated in activities. NA-C stated R4, R9, R49 were cognitively impaired and not able to verbalize if they would want to wear a gown during activities. NA-C stated a reasonable person would not wear a hospital gown during an activity. On 4/8/25 at 10:16 a.m., during telephone interview R49's family member (FM)-A stated R49	F 550		

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F 550	Continued From page 6 was a modest person and would not want wear a hospital gown while participating in activities. FM-A stated R49 was no longer able to make decisions or speak for herself. On 4/8/25 at 11:53 a.m., the director of nursing (DON) stated stated residents were not expected to wear a gown while participating in activities in a common area unless a blanket was placed over the resident's lap, or a sweater covering the upper body. The DON confirmed R4, R9, R49 were not able to verbalize if they had concerns with wearing a gown during activities and families had not been asked the resident preference. The DON stated resident's in other areas of the facility do not participate in activities wearing hospital gowns. Facility Resident Right to Receive Respect and Dignity policy dated 10/20/23, indicated It is the goal to provide dignity and respect to all residents in full recognition of their individuality. This includes but is not limited to the following: The right to retain personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 550		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		5/8/25

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F 644	Continued From page 7 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority -SMHA) for 2 of 2 resident (R10 and R14) with new onset of mental illness since admission. Findings include: R10's 7/05/23, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II (PASARR) to be completed. R10's 12/26/24, quarterly Minimum Data Set (MDS) assessment identified R10 was admitted July 2023. R10 had a diagnoses of non-traumatic brain dysfunction, dementia, anxiety, depression, and a psychotic disorder other than schizophrenia. R10 was severely cognitively impaired and took antipsychotic, antidepressant, and antianxiety medication on a routine basis.	F 644	As directed by the MN Department of Human Services Bulletin #24-25-01, St. Luke's Lutheran Care Center will notify the County Mental Health Authority anytime a resident receives a new serious mental illness diagnosis that significantly changes a person's mental health symptoms or their need for mental health services, in order to request that the county does a Level II Mental Illness Screening. According to MDHS Bulletin #24-25-01, the National Institute of Mental Health defines a serious mental illness as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Qualifying diagnoses include, but are not limited to Schizophrenia, Schizoaffective Disorder, Bipolar Disorder I and II, Major Depressive Disorder,	

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F 644	Continued From page 8 R10 was dependent on staff for cares and activities of daily living (ADLs). Section D-Mood, on the MDS, identified R10 had little interest or pleasure in doing things, felt down, depressed or hopeless, had trouble falling, staying asleep or slept too much, felt bad about herself, had let herself or family down, had trouble concentrating on things, moved or spoke slowly that other people would noticed, was fidgety, restless, stated that life isn't worth living, wished for death or attempt to harm self, was short tempered, and easily annoyed never to 1 day. R10 had felt tired, had little energy, had poor appetite or was overeating 12 to 14 days, during the 14-day assessment period. R10's undated, current diagnosis list identified R10 received a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 9/07/23. R10's undated, current care plan identified R10 was at risk for alteration in mood and behaviors related to late Alzheimer's dementia with psychotic disturbances, anxiety, unspecified psychosis not due to substance or known physiological condition and depression disorder. R10 had a history of verbal outburst, not wanting to be alone at times, physical aggression towards staff, and confusion. R10 was at risk for psychotropic medication side effects such as constipation, nausea, fatigue, poor appetite, dizziness and nervousness, and adverse drug reactions. R10 was at risk for psychosocial well-being related to traumatic life events of R10's past and present. Interventions was for staff to provide referrals to mental health professional, support groups and other appropriate resources as needed.	F 644	Agoraphobia, Panic Disorder, Generalized Anxiety Disorder, Post Traumatic Stress Disorder, and all cluster A and Cluster B Disorders. When a current resident receives a new serious mental illness diagnosis or is started on an antipsychotic medication related to a serious mental illness diagnosis, the facility's Interdisciplinary Team (IDT) in collaboration with the resident's physician will discuss if the diagnosis or medication is related to a Neurocognitive Disorder such as Dementia, Alzheimer's or a related disorder. If so, the reasons for not referring the resident to the County Mental Health Authority will be documented and care planned. If the IDT and physician feels that the diagnosis or medication is due to a change that substantially interferes with or limits the resident's major life activities, the local mental health authority will be notified, and they will determine if a Level II Screening for mental illness is needed. If a resident is transferred to a psychiatric hospital for services, St. Luke's will initiate a new PAS and Level II Screening before they return to St. Luke's. When Level II screening referrals are made to our Local Mental Health Authority (LMHA), the LMHA is responsible to know mental health services available in the area. The LMHA is also responsible to recommend appropriate mental health services for individuals who have a serious mental illness and are receiving nursing facility care. St. Luke's will document, care plan, and help implement	

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F 644	Continued From page 9 R10's medical record lacked any indication that the county (SMHA) had been notified since the new onset of R10's mental illness. R14's 11/10/16, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II (PASARR) to be completed. R14's 5/24/18, Confidential Protected Health Information Enclosed faxed sheet identified a notice of voluntary transfer of R14 to the local hospital for changes in behavior. R14's 12/06/24, Risk and Benefit Assessment and Psych Summary identified R14 had a history of paranoia and delusions, was anxious, had thoughts of people talking about him and listening to his conversations, and had made bizarre verbal statements. R14's 1/10/25, quarterly Minimum Data Set (MDS) was admitted September 2017. R14 had a diagnosis of depression and schizophrenia. R14 was cognitively intact and took antipsychotics and antidepressants on a routine basis. R14 required substantial/maximal assistance for cares and was dependent on staff for transfers. Section D-Mood, on the MDS, identified R14 had little interest or pleasure in doing things and had felt down, depressed, or hopeless never to 1 day, during the 14-day assessment period. R14's undated, current diagnosis list identified R14 received a new diagnosis of paranoid delusional disorder on 7/05/18, social phobia on 6/11/20 and schizoaffective disorder, depressive type on 6/11/20.	F 644	any recommendations made by the LMHA. On 5/6/25, the Director of Social Services sent a referral to Faribault County's Local Mental Health Authority (LMHA) for R10 and R14 for them to determine if a Level II Screening for mental illness is needed. On a monthly basis, the Director of Social Services or designee will audit the health record of residents who receive a new serious mental illness diagnosis or are started on an antipsychotic medication related to a serious mental illness diagnosis to determine compliance with facility protocol as stated above. Results will be used to guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment Performance Improvement (QAPI) Committee Meetings. After 1 year, the QAPI Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Social Services is responsible for overall compliance with this regulation.	

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F 644	Continued From page 10 R14's undated, current care plan identified R14 was at risk for alteration in mood related to depressive disorder, and delusional disorder. R14 had a history of suicidal thoughts or hurting oneself, auditory hallucinations and delusions. R14 was at risk for antidepressant antipsychotic medication use and had target behaviors of paranoia, anger and impatience. R14's medical record lacked any indication that the county (SMHA) had been notified since the new onset of R14's mental illness. Interview on 4/08/25 at 2:25 p.m., with licensed social worker identified the facility relied on the hospital to initiate the PASARR prior to admission. She identified she was not aware R10 and R14 new mental illness diagnoses. She identified the mental health authority was not contacted for referral. Interview on 4/09/25 at 11:06 a.m., with director of nursing had no knowledge of when to determine a Level II screening would be required. She stated her expectations would be for the facility to identify a process to review residents with a new mental illness for a Level II screening. Review of September 2024 Preadmission Screening Process For Entering A SNF policy identified Level I PASARR would be completed on residents before admission to the facility. In addition, the facility would notify the state mental health authority or state intellectual disability authority after a significant change in the mental or physical condition or a resident who had a mental illness or intellectual disability.	F 644		

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F 692	Continued From page 11	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, comprehensively assess and implement interventions for a 9.7 percent weight loss in one month for of 1 of 1 resident (R19) reviewed for nutrition. Findings include: R19's quarterly Minimum Data Set (MDS) assessment dated 2/3/25, indicated R19 had moderately impaired cognition, no behaviors or rejection of care, a weight of 213 pounds, had a	F 692	St. Luke's Lutheran Care Center's Unplanned Weight Loss Management Policy and Procedure clearly defines the procedure for monitoring resident weights. The Nursing Department works in collaboration with the Dietary Department and Registered Dietician to provide a plan of care that supports each resident's optimal level of wellness, including acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible.	4/30/25

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F 692	Continued From page 12 loss of 5% or more in the last month or loss of 10% or more in the last months and was not on physician prescribed weight loss regimen, required set up assistance with eating, dependent on staff for toileting, dressing, and required moderate assistance with personal hygiene, and diagnoses included hemiplegia or hemiparesis (weakness or partial paralysis on one side of the body), depression and weakness. R19's nutritional status Care Area Assessment (CAA) worksheet dated 5/16/24, indicated potential for alterations in nutritional status secondary to BMI (body mass index), at risk for weight gain or loss, dehydration, and/or skin breakdown, see nutritional documents, diagnosis list, physician orders, will proceed to nutritional care plan to address needs. R19's care plan dated 2/17/25, indicated potential for alteration in nutrition related to cerebral infarction (stroke) and interventions included diet: regular with average sized portions, regular liquid consistencies and regular texture foods, provide meals upon her request, independent with feeding herself, provide/set up as needed, encourage to eat, monitor food and fluid intake at meals, acceptance and tolerance to diet. Document titled MDS Listing Checklist dated 2/12/25, indicated current weight 213, weight one month ago 236, weight loss 9.75% in month, weight 6 months ago 234, significant weight change yes, regular diet, appetite varies, supplements in diet order. Progress note dated 11/7/24, dietary manager (DM)-A indicated R19 receiving a general diet with regular food textures and regular liquid	F 692	R19's weight recorded on 2/1/25 was 213 pounds, 23 pounds less than she weighed the previous month. The facility Unplanned Weight Loss Management Policy and Procedure identifies the RN Resident Care Coordinator (RCC) as being responsible for reviewing monthly weights, determining the need for re-weighs, and notification of families, dietician, and physician as appropriate. In this isolated incident, there is no documentation noted for follow-up. On 4/16/25, DON reviewed the facility's Unplanned Weight Loss Management Policy and Procedure at a Nursing Department Meeting. At the IDT Morning Meeting on 4/30/25, the DON discussed R19's recorded weight from 2/1/25 and lack of evidence of follow-up. The decision was made to implement the following plan to prevent the recurrence of failure to follow-up on a significant change in weight for R19. Per facility protocol, monthly weights are to be completed during the first week of each month. On a monthly basis, the DON will send an email calendar reminder out during the first week of each month for the RCC to review R19's monthly weight. In addition, a Monthly Weight Review Form will be completed by the RCC and shared at an IDT meeting to ensure the appropriate follow-up of a significant weight change. Per facility protocol, monthly weights for all facility residents are to be completed during the first week of each month. On a monthly basis, the DON will send an email calendar reminder during the first week of each month for the RCC's to review the	

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F 692	Continued From page 13 consistencies, consuming approximately 75-100% of food served at 3 meals daily, this is good to excellent intake, able to feed self after tray is set up, most recent weight: 242 pounds,which is up 4 pounds from last month, no issues chewing or swallowing, skin is intact, continue to monitor weight, intake, and acceptance and tolerance to diet. R19's progress note dated 3/25/25 registered dietician (RD)-A indicated R19 had a significant weight change, as defined by regulatory standards, in the last 30-day reporting period, weight history is as follows: most recent weight: 245 pounds, BMI=46.3 (extreme obesity), based on 61 inches, 30-day weight: 213 pounds, up 32 pounds; 15% 165-day admission weight: 238 pounds, up 7 pounds, 3%; receives a general diet with regular food textures and regular liquid consistencies, consumes approximately 75% of food served at 3 meals daily, 90% of the time, this is good to excellent but is in excess of calorie needs, no issues chewing or swallowing, skin is intact, encourage healthful food selection, continue to monitor weight, intake, and acceptance and tolerance to diet. R19's vitals report printed 4/9/25, indicated the following weights: 10/1/24 242 pounds 11/8/24 236 pounds 12/1/24 243 pounds 1/1/25 236 pounds 2/1/25 213 pounds 3/1/25 245 pounds; 5.0 percent change in weight in 30 days 4/1/25 245 pounds On 4/9/25 at 7:34 a.m., during a telephone	F 692	monthly weights of the residents on their hall/station. In addition, a Monthly Weight Review Form will be completed by the RCC's and shared at an IDT meeting to ensure the appropriate follow-up of a significant weight change. On a monthly basis, the Director of Nursing or her designee will randomly monitor resident weights to ensure compliance with the facility's Unplanned Weight Loss Management Policy and Procedure. Results will be used to guide future compliance monitoring and training. In addition, the results will be summarized at the quarterly Quality Assessment Performance Improvement (QAPI) Committee Meetings. After 1 year, the QAPI Committee will re-evaluate the need and frequency for continued compliance monitoring. The Director of Nursing is responsible for overall compliance with this regulation.	

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F 692	Continued From page 14 interview the registered dietician confirmed R19 had a significant weight loss form 1/1/25 to 2/1/25, that was not addressed. RD-A stated interventions were expected implemented with R19's significant weight loss of 9.7% in one month. RD-A stated she was responsible to address significant weight loss and confirmed R19's weight loss was not addressed as expected. On 4/9/25 at 8:25 a.m., RN-B stated the nursing assistants were responsible to weigh and document R19's weight monthly. RN-B stated on 2/1/25, and she reweighed R19's due to the significant weight loss from the previous month and ensure the documentation and weight was not an error. RN-B stated she has no documentation R19's weight on 2/1/25, was an error. RN-B stated a list of resident's weights were given to RN-C, known as the resident care coordinator, to address weights. RN-B stated she would have expected R19's signification weight loss addressed and investigated. On 4/8/25-4/9/25, RN-C was unavailable for an interview. On 4/9/25 at 8:33 a.m., R19 was seated in a wheelchair in the dining room and stated she ate her meal with no concerns. R19 was observed to have ate 100 percent of her breakfast meal. R19 stated she had no weight loss or no weight gain recently and further stated staff checked her weight weekly. On 4/9/25 at 8:35 a.m., dietary manager (DM)-A stated dietary assessed resident weights quarterly and DM-A was observed to find a document titled MDS Listing Checklist dated	F 692		

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F 692	Continued From page 15 2/12/25, and stated the document confirmed R19's significant weight loss. DM-A stated RD-A will address the significant weight loss and gains and was responsible for interventions. On 4/9/25 at 9:57 a.m., registered nurse (RN)-A, also known as the MDS nurse, confirmed R19 had a significant weight loss and confirmed R19's weight loss form 1/1/25 to 2/2/25, was not identified and was not aware of inventions put in place for the R19's weight loss. RN-A further explained R19's weight was maybe an error; however, the weight loss was not investigated to determine if R19 had actual weight loss or an error. On 4/9/25 at 9: 59 a.m., the director of nursing (DON) stated she would expect R19's weight loss on 2/1/25, identified and interventions put in place to follow the facilities policy and procedure. The DON further indicated there was not documentation R19's weight loss was identified or addressed. Facility Unplanned Weight Loss Management policy dated 1/18, indicated committed to providing a plan of care that supports each resident's optimal level of wellness. This includes acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that this is not possible. Procedure: All residents are weighed upon admission, readmission and at least monthly on an ongoing basis. Residents at risk of weight loss are scheduled for more frequent weights as deemed appropriate by	F 692		

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F 692	Continued From page 16 the health care team. Resident weights are taken and entered into their electronic health record. The RN Resident Care Coordinator is responsible for reviewing weights and determining the need for re-weights and notification of dietician and physician. Triggers for weight loss concern include 5% weight loss in one month and 10% weight loss in six months. The Registered Dietician reviews residents' nutritional status with the MDS schedule and upon notification of concerns by Dietary Manager and/or Nursing Department staff. After review, the Registered Dietician will make recommendations that will be communicated to the resident's physician.	F 692		