

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered January 13, 2022

Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

RE: CCN: 245338 Cycle Start Date: November 17, 2021

Dear Administrator:

On January 3, 2022, the Minnesota Department of Health 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.

M. Ping

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 8, 2021

Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

RE: CCN: 245338 Cycle Start Date: November 17, 2021

Dear Administrator:

On November 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

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- 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" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 February 17, 2022 (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).

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In addition, if substantial compliance with the regulations is not verified by May 17, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	Сом	E SURVEY PLETED
		245338	B. WING			C 17/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	1772021
				901 LUTHER PLACE		
31 30 11	IS LUTHERAN HOME			ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 00	00		
	conducted at your f to be NOT in comp	ndard abbreviated survey was facility. Your facility was found liance with the requirements of art B, Requirements for Long s.				
		plaint was found to be H5338064C (MN70122), with t (F580).				
	The following comp UNSUBSTANTIATE H5338063C (MN71 H5338062C (MN71 H5338061C (MN78	232) 472)				
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 580 SS=D	onsite revisit of you validate that substa regulations has bee Notify of Changes (Injury/Decline/Room, etc.)	F 58	30		12/29/21
	(i) A facility must im consult with the res consistent with his representative(s) w	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which				
LABORATORY	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					12/13/2021

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.

PRINTED: 12/19/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/19/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245338	B. WING				C I 7/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME				901 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	results in injury and physician intervention (B) A significant char mental, or psychoso deterioration in hear status in either life-to- clinical complication (C) A need to alter to a need to discontinue treatment due to add commence a new for (D) A decision to tra- resident from the far §483.15(c)(1)(ii). (ii) When making nor (14)(i) of this section all pertinent informa- is available and pro- physician. (iii) The facility mus- resident and the res- when there is- (A) A change in roo as specified in §483 (B) A change in res- State law or regulat (e)(10) of this section (iv) The facility mus- update the address phone number of the representative(s). §483.10(g)(15) Admission to a com- that is a composite §483.5) must disclo- its physical configur	has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or ansfer or discharge the notification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the t also promptly notify the sident representative, if any, m or roommate assignment 8.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. t record and periodically (mailing and email) and	F	580			

If continuation sheet Page 2 of 10

CENTE	-	AND HUMAN SERVICES			O		APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245338	B WING			(
	PROVIDER OR SUPPLIER	240000		_	TREET ADDRESS, CITY, STATE, ZIP CODE	11/1	7/2021
					01 LUTHER PLACE		
ST JOHN	IS LUTHERAN HOME				ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 580	Continued From pa	ae 2	F 5	580			
	part, and must spec room changes betw under §483.15(c)(9 This REQUIREMEN by: Based on observat review, the facility f a timely manner of resident (R3) who f Findings include: R3's face sheet prin diagnoses of multip side, and history of R3's quarterly Minin assessment, dated intact cognition, add clear speech, unde make herself under with bed mobility, re one staff when tran wheelchair and wal extensive assistance On 8/12/19, R3's pl fall risk due to impa physical impairment falls. A subsequent fall or injure herself light in reach, envirt	cify the policies that apply to veen its different locations). NT is not met as evidenced tion, interview, and document ailed to notify the physician in a significant change for 1 of 1 fell, sustaining rib fractures. neted 11/17/21, indicated ole fractures of ribs on the left falling and muscle weakness. mum Data Set (MDS) 12/16/20, indicated R3 had equate vision and hearing, rstood others and was able to rstood. R3 was independent equired limited assistance of sferring from bed to king in her room, and required be of one staff for toileting. an of care indicated R3 was a aired mobility related to t, weakness and history of goal identified R3 would not . Interventions included: call onment free of obstacles, bed juent checks for positioning,		000	Corrective action for those resident affected On 2/13/2021, R3 fell in her room. A time of the fall, R3 had to complaint pain. In the evening of 2/13/2021 R verbalized rib pain to LPN-A. LPN-A CNP-A, but was unable to reach hir LPN-A contacted R3's family, who v she wanted her treated with Tylenol that didn't help she may want her set the ER. On 2/15/2021 a TO was reac from the physician to get a PPX for pain. The PPX was completed on 2 resulted on 2/14/21 showing finding acute fractures of left 8th and 9th ril The physician was updated with x-r results and an order was received f lidocaine patch to left rib area daily. 2/18/21, it was notified by RN-C that rib pain was relieved by lidocaine at scheduled Tylenol. Identify other residents All residents have the potential to b impacted by alleged deficient practi Systemic change Change of Condition policy was upor to include definitions and examples short-term change of conditions and	At the ts of 3 A called m. voiced and if ent to ceived her rib /16/21, js of bs. ay or On t #3's nd e ce. dated or d	
	R3's physician orde received Tylenol ES twice a day for pain	nd floor mat by bed and chair. ers dated 6/19/20, indicated R3 S (extra strength), two tablets or fever. R3 also had order tablets daily PRN (as needed).			significant change of conditions. Nu meetings will be held on 12/20/21 a 12/22/21 to review the change in po and re-educate on change of condit notification. Nurses who are unable attend the meeting will be given the	nd blicy tion to	

Facility ID: 00138

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		AND HUMAN SERVICES				FORM	12/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245338	B. WING				C 17/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME				01 LUTHER PLACE LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 3	F	580		- 4 : 4 -	
F 580	A fall risk assessme indicated R3 was a R3's post fall invest 7:08 a.m. indicated attempted to ambul own. A new interver assistance with toild day shift or end of o awake. Progress note date registered nurse (R a.m., staff heard a and found her lying her recliner and the was going to the ba fell. R3 denied pain recliner using a me approximately 5:00 ambulating in her ro reminded to use he Progress note date licensed practical n had left sided pain ribs are broken." Ty prior to this at 4:15 of pain and noted F	ent conducted on 12/15/20, high fall risk. igation report dated 2/13/21 at a fall occurred when R3 late to the bathroom on her ntion was added to offer eting at the beginning of the overnight shift if R3 was d 2/13/21, at 7:03 a.m., by N)-A indicated that at 6:24 noise and went to check on R3 on the floor mid-way between bathroom. R3 told staff she throom, lost her balance and and was assisted to her chanical lift. Prior to the fall, at a.m., R3 had been seen bom using her walker and was r call light for assistance. d 2/13/21, at 5:09 p.m. by urse (LPN)-A, indicated R3 and told LPN-A, "I think my lenol had been given for pain p.m. LPN-A palpated the area R3 grimaced with pain in her	F	580	information by 12/31/21. A phone li the attending physicians/NPs, on ca physicians/NP, and fax numbers ha created and posted in the nurses of Monitor deficient practice The Administrator, Director of Nurs and Social Services designee will r and initial the 24 hour reports for an change of statuses to ensure they a followed up on timely and correctly practice will continue for three mon longer if needed. Medical records receives 24 hours reports and will e the Administrator, Director of Nursi Social Services designee reviewed initialed. Completion date 12/29/2021	all ffices. ing, eview ny are . This ths, or ensure ng, and	
	deformity was observed Progress note date LPN-A indicated R3 been called and up stated "if Tylenol do go to the ER (emer	No redness, discoloration or erved. d 2/13/21, at 5:12 p.m., by b's family member (FM)-B had dated on R3's condition. FM-B besn't help, I might want her to gency room)." LPN-A placed a se practitioner (CNP)-A, but					

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		AND HUMAN SERVICES				FORM): 12/19/2021 // APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245338	B. WING	i		11	C / 17/2021
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	NS LUTHERAN HOME				01 LUTHER PLACE LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 580	was not able to read indication in the pro- was left, or if LPN-A later, or if another p Progress note dated (RN)-B indicated R3 bed during the nigh looked like R3's left facial expression. Progress note dated LPN-A indicated R3 many times self-trai and without her wal call light for assistant hurt but she was se wheelchair or edge stretching without g Progress note dated (LPN)-B indicated F	ch him. There was no ogress notes that a message A attempted to reach CNP-A provider was contacted. d 2/14/21, at 6:51 a.m., by 3 was actively moving about in at independently, and at times t side was hurting per her d 2/14/21, at 9:31 p.m., by 3 had been seen in her room insferring and ambulating with lker. R3 was reminded to use ince. R3 reported her left side een leaning from her of bed; bending and grimacing or complaints. d 2/15/21, at 1:25 p.m. by R3 had pain to her left ribs with	F	580			
	palpation, but did no that point. FM-B wa R3 needed an xray.	ot flinch or complain of pain at as present and questioned if . LPN-B noted she would an to update him and see what					
	unit coordinator (HU order was received	d 2/15/21, at 3:26 p.m., health UC)-C indicated a telephone from the physician to get a (Professional Portable X-Ray)					
	indicated R3 had be when staff was not ask for assistance.	d 2/15/21, 9:10 p.m., (LPN)-D een moving about in her room around and was reminded to R3 complained of left rib pain and sudden movements.					

Facility ID: 00138

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	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION			E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	I `		i			PLETED
							(C
		245338	B. WING	_			11/*	17/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	IP CODE		
ST JOHN	IS LUTHERAN HOME				901 LUTHER PLACE ALBERT LEA, MN 56007			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	CORRECTION	1	(X5)
PRÉFIX		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACT CROSS-REFERENCED TO T			COMPLETION DATE
TAG	REGULATORTOR		IAG		DEFICIENC			
			1					
F 580	Continued From pa	ge 5	F 5	580	1			
	Progress note date	d 2/16/21, at 12:22 a.m. by						
		had been moaning with each						
	movement, and rep	orted pain in left, lateral						
	abdominal area. Ty	lenol was given for pain.						
	R3's medication ad	ministration record from 2/13						
	to 2/17/21, R3 rated	her pain between 3 and 7/10,						
		doses of Tylenol ES on						
		n. for 8/10 pain in left side and 21, at 12:21 a.m., for moaning						
		change position and pain in						
	left lateral abdomination	al area. Pain score was						
		nown. Both doses were						
	documented as being	ng effective for pain.						
	R3's radiology repo	rt from PPX indicated R3's						
		d on 2/16/21, at 12:55 p.m. At						
		rt was electronically signed by the the results: acute (sudden						
		the left 8th and 9th ribs noted.						
	,							
		d 2/16/21, at 2:01 p.m. by						
	pain when sitting.	R3 complained of left sided						
	pair mor oning.							
		d 2/16/21, at 11:04 p.m.,						
	(RN)-C indicated xr fractures of left 8th	ay findings revealed acute						
		2/17/21, at 8:25 a.m. by						
		/I-B was notified of xray						
	results.							
	Progress note date	d 2/17/21, at 1:51 p.m., by						
	LPN-C indicated the	e physician was updated with						
		order was received for eft rib area daily. FM-B was						
	updated.	aita ualiy. Fivi-D Was						

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PRINTED: 12/19/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/19/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245338	B. WING				C 17/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME				01 LUTHER PLACE LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 6	Ft	580			
		/17/21, at 6:50 p.m., by RN-C aced on two assist with ent fall.					
	indicated R3's rib p	/18/21, at 7:35 p.m., by RN-C ain was relieved by lidocaine aminophen (generic name for					
	12:51 p.m., her pro- 2/14/21 were read to recalled why she cat (CNP)-A, LPN-A state because R3 was had for an xray if FM-B added that CNP-A of if it would have bee called the hospital - emergency because some pain, she was stated she didn't real message and state she tried calling him	interview on 11/17/21, at gress notes from 2/13 and o (LPN)-A. When asked if she illed certified nurse practitioner ated she probably called him aving pain and to get an order wanted to do that. LPN-A did not always answer, adding n emergent she would have - "I didn't feel it was an e although R3 was having s moving about freely." LPN-A call if she left CNP-A a phone d if she didn't document that n again, she probably did not.					
	was in her room in recall a fall where s	on 11/17/21, at 1:08 p.m. R3 her wheelchair. R3 did not he broke her ribs, adding ber and could be contacted.					
	director of nursing (R3's progress notes reading them, the D stood out to her. Th should have contact pain. They kept not	on 11/17/21, at 1:14 p.m. DON) was asked to review s from 2/13 to 2/17/21. After DON was asked if anything te DON stated, "Just that they ted a physician about the rib ing it, but did nothing." The build have expected LPN-A to					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245338	B. WING				C 1 7/2021
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME				01 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	keep trying to reach perused it further" a have called again th worked. Looking at stated LPN-B who w have followed up or provider had been r think of a reason st provider"They sh were having problem could have called m direction." When as care in a timely man a fall on 2/13, the D received care in a ti admitted this was th delay in care. The D administrator, the s "IPN" notes (progree could not speak to H adding, "I can't reca appears the delay w it was that the phys xray result more that were available to th provider would have results too, although process occurred. " of nursing homes the delay." The DOI should have left a m him again, called ar the administrator kr clinical decision ma that the nurses prote	n CNP-A, "She should have and added that LPN-A should be following day when she the progress notes, the DON was a full time nurse, should in R3's pain to determine if the notified. The DON could not aff would not call a ould have called, and if they ms reaching a provider, they he and I would provide sked if she felt R3 received nner for her rib pain following ON stated she did not feel R3 imely manner. The DON he first she had heard of this	F	580			

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		AND HUMAN SERVICES				FORM	12/19/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245338	B. WING				C 17/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME				001 LUTHER PLACE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	On 11/17/21, at 2:3 FM-B and message During an interview administrator stated fall today, as well as The administrator s Tylenol didn't work, the ER. The admini Tylenol had been w continued to docum When asked if she be notified after a fa pain, the administra- to inform a provider LPN-A left a messa been documented. During a telephone p.m. FM-B stated s from February when FM-B admitted bei until she suggested despite R3 complai "It wasn't until I said X-ray." Facility policy titled with revised date of resident fell, the prin practitioner would b Facility policy titled Physician/NP (nurs Policy, dated 11/200 physician/NP or phy notified of changes health status. The p	5 p.m., a call was placed to	F	580			

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245338	B. WING				C 17/2021
NAME OF	PROVIDER OR SUPPLIER	•		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
STUOH	IS LUTHERAN HOME				901 LUTHER PLACE		
					ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	and DON. Staff we	ige 9 re to document the time of the d the results or orders	F	580			

If continuation sheet Page 10 of 10

PRINTED: 12/19/2021



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 8, 2021

Administrator St Johns Lutheran Home 901 Luther Place Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders Event ID: 2WJR11

Dear Administrator:

The above facility was surveyed on November 17, 2021 through November 17, 2021 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 <u>only a suggestion</u> 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

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

St Johns Lutheran Home December 8, 2021 Page 2

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

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

Please feel free to call me with any questions.

Mitig

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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00138	B. WING		C 11/17/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		ER PLACE LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	at your facility by su Department of Hea found NOT in comp Licensure. Please in of correction you had identify the date wh	TS: aplaint survey was conducted irveyors from the Minnesota lth (MDH). Your facility was bliance with the MN State ndicate in your electronic plan ave reviewed these orders and en they will be completed.				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

Minneso	ta Department of He	alth	-		1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			_
		00138	B. WING			C 17/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		901 LUT	HER PLACE			
SIJOHN	IS LUTHERAN HOME	ALBERT	LEA, MN 560	07		
(X4) ID	_		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	•	-				
		laint was found to be H5338064C (MN70122) with sued.				
	The following comp	laints were found to be				
	H5338063C (MN71	232)				
	H5338062C (MN71 H5338061C (MN78					
		nent of Health is documenting Correction Orders using				
	Federal software. T	ag numbers have been				
		ota state statutes/rules for				
		e assigned tag number eft column entitled "ID Prefix				
		tute/rule out of compliance is				
		ary Statement of Deficiencies'	•			
		es the "To Comply" portion of				
		r. This column also includes				
		are in violation of the state				
		tement, "This Rule is not met				
		ollowing the surveyor's findings Method of Correction and				
	Time Period for Co					
		participate in the electronic				
		nsure orders consistent with				
	the Minnesota Depa	artment of Health				
		in 14-01, available at				
		state.mn.us/facilities/regulatio				
		1.html The State licensing				
		ed on the attached Minnesota				
		lth orders being submitted to Although no plan of correction				
		ate Statutes/Rules, please				
		RRECTED" in the box				
		ou must then indicate in the				
		ensure process, under the				
		date, the date your orders wil				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00138	B. WING			17/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ST JOHN	IS LUTHERAN HOME		HER PLACE	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	the Minnesota Depa is enrolled in ePOC	o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			12/29/2
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	C. a need to al	ter treatment significantly, for				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (.	X3) DATE SURVEY COMPLETED
		00138	B. WING		C 11/17/2021
	PROVIDER OR SUPPLIER	STREET AF		STATE, ZIP CODE	
	-ROVIDER OR SUFFLIER			STATE, ZIF CODE	
ST JOHN	IS LUTHERAN HOME		LEA, MN 56	6007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
2 265	Continued From pa	ge 3	2 265		
		discontinue an existing form adverse consequences, or to f treatment;			
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or			
	E. expected an	d unexpected resident deaths.			
	by: Based on observati review, the facility fa a timely manner of	ent is not met as evidenced on, interview, and document ailed to notify the physician in a significant change for 1 of 1 ell, sustaining rib fractures.		Systemic change Change of Condition policy was upd to include definitions and examples short-term change of conditions and	or
	Findings include:			significant change of conditions. Nu meetings will be held on 12/20/21 at 12/22/21 to review the change in po	nd
	diagnoses of multip	nted 11/17/21, indicated le fractures of ribs on the left falling and muscle weakness.		and re-educate on change of condit notification. Nurses who are unable attend the meeting will be given the information by 12/31/21. A phone lis	ion to
	assessment, dated intact cognition, add clear speech, under make herself under with bed mobility, re one staff when trans wheelchair and wall	num Data Set (MDS) 12/16/20, indicated R3 had equate vision and hearing, rstood others and was able to stood. R3 was independent equired limited assistance of sferring from bed to king in her room, and required are of one staff for toileting.		the attending physicians/NPs, on ca physicians/NP, and fax numbers ha created and posted in the nurses of Monitor deficient practice The Administrator, Director of Nursii and Social Services designee will re and initial the 24 hour reports for an change of statuses to ensure they a followed up on timely and correctly. practice will continue for three mont	II s been fices. ng, eview y re This
	fall risk due to impa	an of care indicated R3 was a ired mobility related to t, weakness and history of		longer if needed. Medical records re 24 hours reports and will ensure the Administrator, Director of Nursing, a	eceives

If continuation sheet 4 of 11

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00138	B. WING			0 17/2021
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IS LUTHERAN HOME			07		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLE DATE
Continued From pa	age 4	2 265			
proper shoe gear a	and floor mat by bed and chair.				
received Tylenol ES twice a day for pair for Tylenol ES, two A fall risk assessm	S (extra strength), two tablets n or fever. R3 also had order tablets daily PRN (as needed) ent conducted on 12/15/20,				
7:08 a.m. indicated attempted to ambu own. A new interve assistance with toil	I a fall occurred when R3 late to the bathroom on her ntion was added to offer eting at the beginning of the				
registered nurse (F a.m., staff heard a and found her lying her recliner and the was going to the ba fell. R3 denied pair recliner using a me approximately 5:00 ambulating in her r	RN)-A indicated that at 6:24 noise and went to check on R3 g on the floor mid-way between e bathroom. R3 told staff she athroom, lost her balance and n and was assisted to her echanical lift. Prior to the fall, at 0 a.m., R3 had been seen oom using her walker and was				
licensed practical r had left sided pain ribs are broken." Ty prior to this at 4:15 of pain and noted F left mid-back area.	nurse (LPN)-A, indicated R3 and told LPN-A, "I think my ylenol had been given for pain p.m. LPN-A palpated the area R3 grimaced with pain in her No redness, discoloration or				
	OF CORRECTION PROVIDER OR SUPPLIER IS LUTHERAN HOME SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From par proper shoe gear a R3's physician order received Tylenol ES twice a day for pair for Tylenol ES, two A fall risk assessm indicated R3 was a R3's post fall inves 7:08 a.m. indicated attempted to ambur own. A new interver assistance with toil day shift or end of awake. Progress note dater registered nurse (Fa a.m., staff heard a and found her lying her recliner and the was going to the ba fell. R3 denied pair recliner using a me approximately 5:00 ambulating in her r reminded to use her Progress note dater icensed practical r had left sided pain ribs are broken." T prior to this at 4:15 of pain and noted F left mid-back area.	OF CORRECTION IDENTIFICATION NUMBER: 00138 00138 PROVIDER OR SUPPLIER STREET AI IS LUTHERAN HOME 901 LUTI ALBERT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 proper shoe gear and floor mat by bed and chair. R3's physician orders dated 6/19/20, indicated R3 received Tylenol ES (extra strength), two tablets twice a day for pain or fever. R3 also had order for Tylenol ES, two tablets daily PRN (as needed) A fall risk assessment conducted on 12/15/20, indicated R3 was a high fall risk. R3's post fall investigation report dated 2/13/21 af 7:08 a.m. indicated a fall occurred when R3 attempted to ambulate to the bathroom on her own. A new intervention was added to offer assistance with toileting at the beginning of the day shift or end of overnight shift if R3 was awake. Progress note dated 2/13/21, at 7:03 a.m., by registered nurse (RN)-A indicated that at 6:24 a.m., staff heard a noise and went to check on R3 and found her lying on the floor mid-way between her recliner and the bathroom, lost her balance and fell. R3 denied pain and was assisted to her recliner using a mechanical lift. Prior to the fall, at approximately 5:00 a.m., R3 had been seen ambulating in her room using her walker and was reminded to use her call light for assistance. Progress note dated 2/13/21, at 5:09 p.m. by licensed practical nurse (LPN)-A, indicated R3 had left sided pain a	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00138 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S SILUTHERAN HOME 901 LUTHER PLACE ALBERT LEA, MN 560 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED DES REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 2 265 Continued From page 4 2 265 proper shoe gear and floor mat by bed and chair. R3's physician orders dated 6/19/20, indicated R3 received Tylenol ES (extra strength), two tablets twice a day for pain or fever. R3 also had order for Tylenol ES, two tablets daily PRN (as needed). A fall risk assessment conducted on 12/15/20, indicated R3 was a high fall risk. R3's post fall investigation report dated 2/13/21 at 7:08 a.m. indicated a fall occurred when R3 attempted to ambulate to the bathroom on her own. A new intervention was added to offer assistance with toileting at the beginning of the day shift or end of overnight shift if R3 was awake. Progress note dated 2/13/21, at 7:03 a.m., by registered nurse (RN)-A indicated that at 6:24 a.m., staff heard a noise and went to check on R3 and found her lying on the floor mid-way between her recliner and the bathroom, lost her balance and fell. R3 denied pain and was assisted to her recliner using a mechanical lift. Prior to the fall, at approximately 5:00 a.m., R3 had been seen ambulating in her room using her walker and was reminded to	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00138 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLUTHERAN HOME 901 LUTHER PLACE ALBERT LEA, MN 56007 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREPIX TAG PROVIDER'S PLAN OF COOSS-REFERENCED TO TO DEFICIENCY Continued From page 4 2 265 2265 Continued From page 5 Extra strength), two tablets twice a day for pain or fever. R3 also had order for Tylenol ES, two tablets daily PRN (as needed). A fall risk assessment conducted on 12/15/20, indicated R3 was a high fall risk. R3's post fall investigation report dated 2/13/21 at 7:08 a.m. indicated fall occurred when R3 attempted to ambulate to the bathroom on her own. 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WING 11/1 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 LUTHER PLACE SILUTHERAN HOME 901 LUTHER PLACE ALBERT LEA, MN 56007 SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID PREFX PROVIDER'S PLAN OF CORRECTION NUMBER: REGULATORY ON LSCIDENTFYING INFORMATION) ID PREFX PROVIDER'S PLAN OF CORRECTION OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 4 2 265 proper shoe gear and floor mat by bed and chair. R3's physician orders dated 6/19/20, indicated R3 received Tylenol ES (extra strength), two tablets twice a day for pain or fever. R3 also had order for Tylenol ES, two tablets daily PRN (as needed)). A fall risk assessment conducted on 12/15/20, indicated R3 was a high fall risk. R3's post fall investigation report dated 2/13/21 at 7:08 a.m. indicated a fall occurred when R3 attempted to ambulate to the bathroom on her own. 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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00138	B. WING			C 17/2021
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	-
	IS LUTHERAN HOME	901 T	HER PLACE			
	S LUTHERAN HOME	ALBERT	LEA, MN 560	07		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	ge 5	2 265			
	been called and upo stated "if Tylenol do go to the ER (emery call to certified nurs was not able to read indication in the pro was left, or if LPN-A	I's family member (FM)-B had dated on R3's condition. FM-B besn't help, I might want her to gency room)." LPN-A placed a be practitioner (CNP)-A, but ch him. There was no bgress notes that a message A attempted to reach CNP-A brovider was contacted.				
	(RN)-B indicated R3 bed during the nigh	d 2/14/21, at 6:51 a.m., by 3 was actively moving about in t independently, and at times side was hurting per her				
	LPN-A indicated R3 many times self-trainand without her wal call light for assistant hurt but she was se wheelchair or edge	d 2/14/21, at 9:31 p.m., by 8 had been seen in her room nsferring and ambulating with ker. R3 was reminded to use nce. R3 reported her left side en leaning from her of bed; bending and rimacing or complaints.				
	(LPN)-B indicated F palpation, but did no that point. FM-B wa R3 needed an xray.	d 2/15/21, at 1:25 p.m. by R3 had pain to her left ribs with ot flinch or complain of pain at is present and questioned if . LPN-B noted she would an to update him and see what				
	unit coordinator (HU order was received	d 2/15/21, at 3:26 p.m., health JC)-C indicated a telephone from the physician to get a (Professional Portable X-Ray)				
	Progress note date	d 2/15/21, 9:10 p.m., (LPN)-D				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00138	B. WING		11/	17/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST JOHN	NS LUTHERAN HOME		HER PLACE LEA, MN 560	07		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	ge 6	2 265			
	when staff was not ask for assistance. with lifting her arms Progress note date RN-A indicated R3 movement, and rep	een moving about in her room around and was reminded to R3 complained of left rib pain and sudden movements. d 2/16/21, at 12:22 a.m. by had been moaning with each ported pain in left, lateral lenol was given for pain.				
	to 2/17/21, R3 rated and received PRN of 2/13/21, at 4:27 p.n back, and on 2/16/2 when attempted to left lateral abdomin documented as un	ministration record from 2/13 d her pain between 3 and 7/10 doses of Tylenol ES on n. for 8/10 pain in left side and 21, at 12:21 a.m., for moaning change position and pain in al area. Pain score was known. Both doses were ng effective for pain.				
	xray was completed 3:26 p.m., the report a PPX physician with	rt from PPX indicated R3's d on 2/16/21, at 12:55 p.m. At rt was electronically signed by th the results: acute (sudden the left 8th and 9th ribs noted.				
		d 2/16/21, at 2:01 p.m. by R3 complained of left sided				
		d 2/16/21, at 11:04 p.m., ay findings revealed acute and 9th ribs.				
		2/17/21, at 8:25 a.m. by /I-B was notified of xray				
		d 2/17/21, at 1:51 p.m., by e physician was updated with				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00138	B. WING			C 17/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ST JOHN	NS LUTHERAN HOME		HER PLACE LEA, MN 560	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 7	2 265			
		order was received for eff rib area daily. FM-B was				
		2/17/21, at 6:50 p.m., by RN-C laced on two assist with cent fall.				
	indicated R3's rib p	2/18/21, at 7:35 p.m., by RN-C pain was relieved by lidocaine taminophen (generic name for				
	12:51 p.m., her pro 2/14/21 were read recalled why she ca (CNP)-A, LPN-A st because R3 was ha for an xray if FM-B added that CNP-A if it would have bee called the hospital emergency becaus some pain, she wa stated she didn't re message and state	e interview on 11/17/21, at ogress notes from 2/13 and to (LPN)-A. When asked if she alled certified nurse practitione ated she probably called him aving pain and to get an order wanted to do that. LPN-A did not always answer, adding en emergent she would have "I didn't feel it was an se although R3 was having s moving about freely." LPN-A call if she left CNP-A a phone ed if she didn't document that n again, she probably did not.	r			
	was in her room in recall a fall where s	v on 11/17/21, at 1:08 p.m. R3 her wheelchair. R3 did not she broke her ribs, adding hber and could be contacted.				
	director of nursing R3's progress note reading them, the I stood out to her. Th	on 11/17/21, at 1:14 p.m. (DON) was asked to review s from 2/13 to 2/17/21. After DON was asked if anything ne DON stated, "Just that they cted a physician about the rib				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00138	(X2) MULTIPLE A. BUILDING: B. WING	CONSTRUCTION	COMI	E SURVEY PLETED C 17/2021
	PROVIDER OR SUPPLIER	STREET AD		TATE, ZIP CODE		
	FROVIDER OR SOFFEIER		ER PLACE	TATE, ZIF CODE		
ST JOHI	NS LUTHERAN HOME		_EA, MN 560	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	ge 8	2 265			
nnesota	DON stated she wo keep trying to reach perused it further" a have called again th worked. Looking at stated LPN-B who have followed up or provider had been of think of a reason st provider"They sh were having proble could have called in direction." When as care in a timely mai a fall on 2/13, the D received care in a t admitted this was th delay in care. The D administrator, the s "IPN" notes (progree could not speak to adding, "I can't reca appears the delay w it was that the phys xray result more tha were available to th provider would have results too, althoug process occurred." of nursing homes the delay." The DO should have left a m him again, called and the administrator kn clinical decision mat that the nurses prof progress notes to b	ing it, but did nothing." The buld have expected LPN-A to a CNP-A, "She should have and added that LPN-A should be following day when she the progress notes, the DON was a full time nurse, should a R3's pain to determine if the notified. The DON could not aff would not call a nould have called, and if they ms reaching a provider, they he and I would provide sked if she felt R3 received nner for her rib pain following ON stated she did not feel R3 imely manner. The DON he first she had heard of this DON stated that the ocial worker and her check ass notes) each morning; but how the delay was missed, all why at this point, but it vas missed." When asked how ician was first notified of the an 24 hours after the results e facility, the DON stated the e received notification of the h she didn't know how that 'He has responsibility for a lot - that could be the reason for N reiterated that the LPN-A nessage for CNP-A, called nother provider, or let her or now. "They need to use their iking skills." The DON added pably were not reading prior e aware of R3 having didn't relay the report of pain				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			~
		00138	B. WING			C 17/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
T JOHN	IS LUTHERAN HOME					
			LEA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 9	2 265			
	On 11/17/21, at 2:3 FM-B and message	35 p.m., a call was placed to e left.				
	administrator state fall today, as well a The administrator s Tylenol didn't work, the ER. The admin Tylenol had been w continued to docum When asked if she be notified after a f pain, the administra to inform a provide LPN-A left a messa been documented. During a telephone p.m. FM-B stated s from February whe FM-B admitted be until she suggested despite R3 compla "It wasn't until I said	y on 11/17/21, at 2:52 p.m. the d she because aware of this is the perceived delay of care. stated FM-B told the staff that it , she might want R3 to go to istrator stated she felt the working, but admitted the staff nent that R3 was having pain. would expect a physician to all in which a resident had ator stated she did expect staff r, adding she didn't know if age, or tried again as it had not e interview on 11/17/21, at 4:46 she recalled her mother's fall ere she sustained broken ribs. ing concerned that it wasn't d it, that an x-ray was obtained ining of pain for several days. d something that they got an				
	with revised date o resident fell, the pr	Fall Assessing and Reporting, f 8/19, indicated that after a imary care provider or nurse be notified of the fall.				
	Physician/NP (nurs Policy, dated 11/20 physician/NP or ph notified of changes health status. The	Change of Condition-Resident e practitioner) Notification 00, indicated the attending ysician/NP on-call would be in a residents condition or procedure was outlined which he providers, nurse manager				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00138	B. WING			C 17/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T JOHN	IS LUTHERAN HOME		HER PLACE LEA, MN 560	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 10	2 265			
		re to document the time of the d the results or orders				
	director of nursing develop/revise and procedures to assu- notified of significan condition timely and treatment, and edu requirements. The	quality assessment and ee could perform random	3			
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty One				