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.

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

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:

- 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).

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245338	A. BUILDING ______ B. WING ______	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/17/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5338064C (MN70122), with a deficiency cited at (F580). The following complaints were found to be UNSUBSTANTIATED: H5338063C (MN71232) H5338062C (MN71472) H5338061C (MN78508) 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 that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		12/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

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F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician in a timely manner of a significant change for 1 of 1 resident (R3) who fell, sustaining rib fractures. Findings include: R3's face sheet printed 11/17/21, indicated diagnoses of multiple fractures of ribs on the left side, and history of falling and muscle weakness. R3's quarterly Minimum Data Set (MDS) assessment, dated 12/16/20, indicated R3 had intact cognition, adequate vision and hearing, clear speech, understood others and was able to make herself understood. R3 was independent with bed mobility, required limited assistance of one staff when transferring from bed to wheelchair and walking in her room, and required extensive assistance of one staff for toileting. On 8/12/19, R3's plan of care indicated R3 was a fall risk due to impaired mobility related to physical impairment, weakness and history of falls. A subsequent goal identified R3 would not fall or injure herself. Interventions included: call light in reach, environment free of obstacles, bed in low position, frequent checks for positioning, 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).	F 580	Corrective action for those residents affected On 2/13/2021, R3 fell in her room. At the time of the fall, R3 had to complaints of pain. In the evening of 2/13/2021 R3 verbalized rib pain to LPN-A. LPN-A called CNP-A, but was unable to reach him. LPN-A contacted R3's family, who voiced she wanted her treated with Tylenol and if that didn't help she may want her sent to the ER. On 2/15/2021 a TO was received from the physician to get a PPX for her rib pain. The PPX was completed on 2/16/21, resulted on 2/14/21 showing findings of acute fractures of left 8th and 9th ribs. The physician was updated with x-ray results and an order was received for lidocaine patch to left rib area daily. On 2/18/21, it was notified by RN-C that #3's rib pain was relieved by lidocaine and scheduled Tylenol. Identify other residents All residents have the potential to be impacted by alleged deficient practice. Systemic change Change of Condition policy was updated to include definitions and examples or short-term change of conditions and significant change of conditions. Nurse meetings will be held on 12/20/21 and 12/22/21 to review the change in policy and re-educate on change of condition notification. Nurses who are unable to attend the meeting will be given the	

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F 580	Continued From page 3 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. R3 told staff she was going to 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 and told LPN-A, "I think my ribs are broken." Tylenol had been given for pain prior to this at 4:15 p.m. LPN-A palpated the area of pain and noted R3 grimaced with pain in her left mid-back area. No redness, discoloration or deformity was observed. Progress note dated 2/13/21, at 5:12 p.m., by LPN-A indicated R3's family member (FM)-B had been called and updated on R3's condition. FM-B stated "if Tylenol doesn't help, I might want her to go to the ER (emergency room)." LPN-A placed a call to certified nurse practitioner (CNP)-A, but	F 580	information by 12/31/21. A phone list with the attending physicians/NPs, on call physicians/NP, and fax numbers has been created and posted in the nurses offices. Monitor deficient practice The Administrator, Director of Nursing, and Social Services designee will review and initial the 24 hour reports for any change of statuses to ensure they are followed up on timely and correctly. This practice will continue for three months, or longer if needed. Medical records receives 24 hours reports and will ensure the Administrator, Director of Nursing, and Social Services designee reviewed and initialed. Completion date 12/29/2021	

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F 580	Continued From page 4 was not able to reach him. There was no indication in the progress notes that a message was left, or if LPN-A attempted to reach CNP-A later, or if another provider was contacted. Progress note dated 2/14/21, at 6:51 a.m., by (RN)-B indicated R3 was actively moving about in bed during the night independently, and at times looked like R3's left side was hurting per her facial expression. Progress note dated 2/14/21, at 9:31 p.m., by LPN-A indicated R3 had been seen in her room many times self-transferring and ambulating with and without her walker. R3 was reminded to use call light for assistance. R3 reported her left side hurt but she was seen leaning from her wheelchair or edge of bed; bending and stretching without grimacing or complaints. Progress note dated 2/15/21, at 1:25 p.m. by (LPN)-B indicated R3 had pain to her left ribs with palpation, but did not flinch or complain of pain at that point. FM-B was present and questioned if R3 needed an xray. LPN-B noted she would contact the physician to update him and see what he recommended. Progress note dated 2/15/21, at 3:26 p.m., health unit coordinator (HUC)-C indicated a telephone order was received from the physician to get a chest xray by PPX (Professional Portable X-Ray) for left rib pain. Progress note dated 2/15/21, 9:10 p.m., (LPN)-D indicated R3 had been moving about in her room when staff was not around and was reminded to ask for assistance. R3 complained of left rib pain with lifting her arms and sudden movements.	F 580		

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F 580	Continued From page 5 Progress note dated 2/16/21, at 12:22 a.m. by RN-A indicated R3 had been moaning with each movement, and reported pain in left, lateral abdominal area. Tylenol was given for pain. R3's medication administration record from 2/13 to 2/17/21, R3 rated her pain between 3 and 7/10, and received PRN doses of Tylenol ES on 2/13/21, at 4:27 p.m. for 8/10 pain in left side and back, and on 2/16/21, at 12:21 a.m., for moaning when attempted to change position and pain in left lateral abdominal area. Pain score was documented as unknown. Both doses were documented as being effective for pain. R3's radiology report from PPX indicated R3's xray was completed on 2/16/21, at 12:55 p.m. At 3:26 p.m., the report was electronically signed by a PPX physician with the results: acute (sudden onset) fractures of the left 8th and 9th ribs noted. Progress note dated 2/16/21, at 2:01 p.m. by (LPN)-C indicated R3 complained of left sided pain when sitting. Progress note dated 2/16/21, at 11:04 p.m., (RN)-C indicated xray findings revealed acute fractures of left 8th and 9th ribs. Progress note date 2/17/21, at 8:25 a.m. by LPN-C indicated FM-B was notified of xray results. Progress note dated 2/17/21, at 1:51 p.m., by LPN-C indicated the physician was updated with xray results and an order was received for lidocaine patch to left rib area daily. FM-B was updated.	F 580		

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F 580	Continued From page 6	F 580		

Progress note on 2/17/21, at 6:50 p.m., by RN-C indicated R3 was placed on two assist with transfers due to recent fall.

Progress note on 2/18/21, at 7:35 p.m., by RN-C indicated R3's rib pain was relieved by lidocaine and scheduled acetaminophen (generic name for Tylenol).

During a telephone interview on 11/17/21, at 12:51 p.m., her progress notes from 2/13 and 2/14/21 were read to (LPN)-A. When asked if she recalled why she called certified nurse practitioner (CNP)-A, LPN-A stated she probably called him because R3 was having pain and to get an order for an xray if FM-B wanted to do that. LPN-A added that CNP-A did not always answer, adding if it would have been emergent she would have called the hospital -- "I didn't feel it was an emergency because although R3 was having some pain, she was moving about freely." LPN-A stated she didn't recall if she left CNP-A a phone message and stated if she didn't document that she tried calling him again, she probably did not.

During an interview on 11/17/21, at 1:08 p.m. R3 was in her room in her wheelchair. R3 did not recall a fall where she broke her ribs, adding FM-B might remember and could be contacted.

During an interview on 11/17/21, at 1:14 p.m. director of nursing (DON) was asked to review R3's progress notes from 2/13 to 2/17/21. After reading them, the DON was asked if anything stood out to her. The DON stated, "Just that they should have contacted a physician about the rib pain. They kept noting it, but did nothing." The DON stated she would have expected LPN-A to

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F 580	Continued From page 7 keep trying to reach CNP-A, "She should have perused it further" and added that LPN-A should have called again the following day when she worked. Looking at the progress notes, the DON stated LPN-B who was a full time nurse, should have followed up on R3's pain to determine if the provider had been notified. The DON could not think of a reason staff would not call a provider...."They should have called, and if they were having problems reaching a provider, they could have called me and I would provide direction." When asked if she felt R3 received care in a timely manner for her rib pain following a fall on 2/13, the DON stated she did not feel R3 received care in a timely manner. The DON admitted this was the first she had heard of this delay in care. The DON stated that the administrator, the social worker and her check "IPN" notes (progress notes) each morning; but could not speak to how the delay was missed, adding, "I can't recall why at this point, but it appears the delay was missed." When asked how it was that the physician was first notified of the xray result more than 24 hours after the results were available to the facility, the DON stated the provider would have received notification of the results too, although she didn't know how that process occurred. "He has responsibility for a lot of nursing homes -- that could be the reason for the delay." The DON reiterated that the LPN-A should have left a message for CNP-A, called him again, called another provider, or let her or the administrator know. "They need to use their clinical decision making skills." The DON added that the nurses probably were not reading prior progress notes to be aware of R3 having continued pain and didn't relay the report of pain to the next shift.	F 580		

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F 580	Continued From page 8	F 580		

On 11/17/21, at 2:35 p.m., a call was placed to FM-B and message left.

During an interview on 11/17/21, at 2:52 p.m. the administrator stated she because aware of this fall today, as well as the perceived delay of care. The administrator stated FM-B told the staff that if Tylenol didn't work, she might want R3 to go to the ER. The administrator stated she felt the Tylenol had been working, but admitted the staff continued to document that R3 was having pain. When asked if she would expect a physician to be notified after a fall in which a resident had pain, the administrator stated she did expect staff to inform a provider, adding she didn't know if LPN-A left a message, or tried again as it had not been documented.

During a telephone interview on 11/17/21, at 4:46 p.m. FM-B stated she recalled her mother's fall from February where she sustained broken ribs. FM-B admitted being concerned that it wasn't until she suggested it, that an x-ray was obtained despite R3 complaining of pain for several days. "It wasn't until I said something that they got an X-ray."

Facility policy titled Fall Assessing and Reporting, with revised date of 8/19, indicated that after a resident fell, the primary care provider or nurse practitioner would be notified of the fall.

Facility policy titled Change of Condition-Resident Physician/NP (nurse practitioner) Notification Policy, dated 11/2000, indicated the attending physician/NP or physician/NP on-call would be notified of changes in a residents condition or health status. The procedure was outlined which included notifying the providers, nurse manager

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	245338	A. BUILDING ______ B. WING ______	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE** **ALBERT LEA, MN 56007**

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F 580	Continued From page 9 and DON. Staff were to document the time of the call, the reason and the results or orders received.	F 580		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

Elizabeth Silkey, 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.

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

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5338064C (MN70122) with a licensing order issued. The following complaints were found to be UNSUBSTANTIATED: H5338063C (MN71232) H5338062C (MN71472) H5338061C (MN78508) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for	2 265		12/29/21

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2 265	Continued From page 3 example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician in a timely manner of a significant change for 1 of 1 resident (R3) who fell, sustaining rib fractures. Findings include: R3's face sheet printed 11/17/21, indicated diagnoses of multiple fractures of ribs on the left side, and history of falling and muscle weakness. R3's quarterly Minimum Data Set (MDS) assessment, dated 12/16/20, indicated R3 had intact cognition, adequate vision and hearing, clear speech, understood others and was able to make herself understood. R3 was independent with bed mobility, required limited assistance of one staff when transferring from bed to wheelchair and walking in her room, and required extensive assistance of one staff for toileting. On 8/12/19, R3's plan of care indicated R3 was a fall risk due to impaired mobility related to physical impairment, weakness and history of falls. A subsequent goal identified R3 would not fall or injure herself. Interventions included: call light in reach, environment free of obstacles, bed in low position, frequent checks for positioning,	2 265	Systemic change Change of Condition policy was updated to include definitions and examples or short-term change of conditions and significant change of conditions. Nurse meetings will be held on 12/20/21 and 12/22/21 to review the change in policy and re-educate on change of condition notification. Nurses who are unable to attend the meeting will be given the information by 12/31/21. A phone list with the attending physicians/NPs, on call physicians/NP, and fax numbers has been created and posted in the nurses offices. Monitor deficient practice The Administrator, Director of Nursing, and Social Services designee will review and initial the 24 hour reports for any change of statuses to ensure they are followed up on timely and correctly. This practice will continue for three months, or longer if needed. Medical records receives 24 hours reports and will ensure the Administrator, Director of Nursing, and Social Services designee reviewed and initialed. Completion date 12/29/2021	

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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. R3 told staff she was going to 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 and told LPN-A, "I think my ribs are broken." Tylenol had been given for pain prior to this at 4:15 p.m. LPN-A palpated the area of pain and noted R3 grimaced with pain in her left mid-back area. No redness, discoloration or deformity was observed.

Progress note dated 2/13/21, at 5:12 p.m., by

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2 265	Continued From page 5	2 265		

Continued From page 5

LPN-A indicated R3's family member (FM)-B had been called and updated on R3's condition. FM-B stated "if Tylenol doesn't help, I might want her to go to the ER (emergency room)." LPN-A placed a call to certified nurse practitioner (CNP)-A, but was not able to reach him. There was no indication in the progress notes that a message was left, or if LPN-A attempted to reach CNP-A later, or if another provider was contacted.

Progress note dated 2/14/21, at 6:51 a.m., by (RN)-B indicated R3 was actively moving about in bed during the night independently, and at times looked like R3's left side was hurting per her facial expression.

Progress note dated 2/14/21, at 9:31 p.m., by LPN-A indicated R3 had been seen in her room many times self-transferring and ambulating with and without her walker. R3 was reminded to use call light for assistance. R3 reported her left side hurt but she was seen leaning from her wheelchair or edge of bed; bending and stretching without grimacing or complaints.

Progress note dated 2/15/21, at 1:25 p.m. by (LPN)-B indicated R3 had pain to her left ribs with palpation, but did not flinch or complain of pain at that point. FM-B was present and questioned if R3 needed an xray. LPN-B noted she would contact the physician to update him and see what he recommended.

Progress note dated 2/15/21, at 3:26 p.m., health unit coordinator (HUC)-C indicated a telephone order was received from the physician to get a chest xray by PPX (Professional Portable X-Ray) for left rib pain.

Progress note dated 2/15/21, 9:10 p.m., (LPN)-D

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2 265	Continued From page 6 indicated R3 had been moving about in her room when staff was not around and was reminded to ask for assistance. R3 complained of left rib pain with lifting her arms and sudden movements. Progress note dated 2/16/21, at 12:22 a.m. by RN-A indicated R3 had been moaning with each movement, and reported pain in left, lateral abdominal area. Tylenol was given for pain. R3's medication administration record from 2/13 to 2/17/21, R3 rated her pain between 3 and 7/10, and received PRN doses of Tylenol ES on 2/13/21, at 4:27 p.m. for 8/10 pain in left side and back, and on 2/16/21, at 12:21 a.m., for moaning when attempted to change position and pain in left lateral abdominal area. Pain score was documented as unknown. Both doses were documented as being effective for pain. R3's radiology report from PPX indicated R3's xray was completed on 2/16/21, at 12:55 p.m. At 3:26 p.m., the report was electronically signed by a PPX physician with the results: acute (sudden onset) fractures of the left 8th and 9th ribs noted. Progress note dated 2/16/21, at 2:01 p.m. by (LPN)-C indicated R3 complained of left sided pain when sitting. Progress note dated 2/16/21, at 11:04 p.m., (RN)-C indicated xray findings revealed acute fractures of left 8th and 9th ribs. Progress note date 2/17/21, at 8:25 a.m. by LPN-C indicated FM-B was notified of xray results. Progress note dated 2/17/21, at 1:51 p.m., by LPN-C indicated the physician was updated with	2 265		

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2 265	Continued From page 7	2 265		

xray results and an order was received for lidocaine patch to left rib area daily. FM-B was updated.

Progress note on 2/17/21, at 6:50 p.m., by RN-C indicated R3 was placed on two assist with transfers due to recent fall.

Progress note on 2/18/21, at 7:35 p.m., by RN-C indicated R3's rib pain was relieved by lidocaine and scheduled acetaminophen (generic name for Tylenol).

During a telephone interview on 11/17/21, at 12:51 p.m., her progress notes from 2/13 and 2/14/21 were read to (LPN)-A. When asked if she recalled why she called certified nurse practitioner (CNP)-A, LPN-A stated she probably called him because R3 was having pain and to get an order for an xray if FM-B wanted to do that. LPN-A added that CNP-A did not always answer, adding if it would have been emergent she would have called the hospital -- "I didn't feel it was an emergency because although R3 was having some pain, she was moving about freely." LPN-A stated she didn't recall if she left CNP-A a phone message and stated if she didn't document that she tried calling him again, she probably did not.

During an interview on 11/17/21, at 1:08 p.m. R3 was in her room in her wheelchair. R3 did not recall a fall where she broke her ribs, adding FM-B might remember and could be contacted.

During an interview on 11/17/21, at 1:14 p.m. director of nursing (DON) was asked to review R3's progress notes from 2/13 to 2/17/21. After reading them, the DON was asked if anything stood out to her. The DON stated, "Just that they should have contacted a physician about the rib

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pain. They kept noting it, but did nothing." The DON stated she would have expected LPN-A to keep trying to reach CNP-A, "She should have perused it further" and added that LPN-A should have called again the following day when she worked. Looking at the progress notes, the DON stated LPN-B who was a full time nurse, should have followed up on R3's pain to determine if the provider had been notified. The DON could not think of a reason staff would not call a provider...."They should have called, and if they were having problems reaching a provider, they could have called me and I would provide direction." When asked if she felt R3 received care in a timely manner for her rib pain following a fall on 2/13, the DON stated she did not feel R3 received care in a timely manner. The DON admitted this was the first she had heard of this delay in care. The DON stated that the administrator, the social worker and her check "IPN" notes (progress notes) each morning; but could not speak to how the delay was missed, adding, "I can't recall why at this point, but it appears the delay was missed." When asked how it was that the physician was first notified of the xray result more than 24 hours after the results were available to the facility, the DON stated the provider would have received notification of the results too, although she didn't know how that process occurred. "He has responsibility for a lot of nursing homes -- that could be the reason for the delay." The DON reiterated that the LPN-A should have left a message for CNP-A, called him again, called another provider, or let her or the administrator know. "They need to use their clinical decision making skills." The DON added that the nurses probably were not reading prior progress notes to be aware of R3 having continued pain and didn't relay the report of pain to the next shift.

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ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE ALBERT LEA, MN 56007**

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2 265	Continued From page 9 On 11/17/21, at 2:35 p.m., a call was placed to FM-B and message left. During an interview on 11/17/21, at 2:52 p.m. the administrator stated she because aware of this fall today, as well as the perceived delay of care. The administrator stated FM-B told the staff that if Tylenol didn't work, she might want R3 to go to the ER. The administrator stated she felt the Tylenol had been working, but admitted the staff continued to document that R3 was having pain. When asked if she would expect a physician to be notified after a fall in which a resident had pain, the administrator stated she did expect staff to inform a provider, adding she didn't know if LPN-A left a message, or tried again as it had not been documented. During a telephone interview on 11/17/21, at 4:46 p.m. FM-B stated she recalled her mother's fall from February where she sustained broken ribs. FM-B admitted being concerned that it wasn't until she suggested it, that an x-ray was obtained despite R3 complaining of pain for several days. "It wasn't until I said something that they got an X-ray." Facility policy titled Fall Assessing and Reporting, with revised date of 8/19, indicated that after a resident fell, the primary care provider or nurse practitioner would be notified of the fall. Facility policy titled Change of Condition-Resident Physician/NP (nurse practitioner) Notification Policy, dated 11/2000, indicated the attending physician/NP or physician/NP on-call would be notified of changes in a residents condition or health status. The procedure was outlined which included notifying the providers, nurse manager	2 265		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00138	A. BUILDING: ______ B. WING ______	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS LUTHERAN HOME	**901 LUTHER PLACE** **ALBERT LEA, MN 56007**

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2 265	Continued From page 10 and DON. Staff were to document the time of the call, the reason and the results or orders received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop/revise and implement policies and procedures to assure the resident's physician is notified of significant change in a resident's condition timely and/or the need to alter treatment, and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		