Electronically delivered
November 3, 2020

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

RE: CCN: 245407
Cycle Start Date: October 14, 2020

Dear Administrator:

On October 14, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On October 7, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have

received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St John Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 14, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 64970
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
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/12, 10/13 and 10/14/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H#5407015C, with a deficiency cited at F689. The following complaint was found to be SUBSTANTIATED with no deficiencies cited due to actions implemented by the facility prior to survey. H#5407014C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to immediately implement assessments and interventions to prevent elopement for residents. The IJ began on 10/6/20 however, the facility immediately	F 000	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 implemented interventions and corrected the deficient practice as of 10/7/20. Therefore, this deficiency is issued as past noncompliance. The above findings constituted substandard quality of care, and an extended survey was conducted 10/14/20.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately implement assessments and interventions to prevent elopement for 3 of 3 residents (R1, R2, and R4) reviewed for elopement. This resulted in an immediate jeopardy (IJ) for R1 who eloped on 10/6/20, at 3:30 a.m. out of the building and went undetected for approximately 30 minutes. R1 was found outside, approximately 62 yards from the building with scrapes to her elbows, knees, toes, fingers and temple. The facility immediately implemented interventions and corrected the deficient practice on 10/6/20. This is issued as past noncompliance at Immediate Jeopardy (IJ). The IJ that began on 10/6/20, was corrected on 10/7/20, when the facility implemented interventions to prevent reoccurrence. The	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

administrator and director of nursing (DON) were notified of the IJ past noncompliance on 10/13/20, at 6:35 p.m. as a result of the immediate corrective action taken by the facility.

Findings include:

R1's diagnoses according to a diagnosis report dated 10/12/20, included Parkinson's disease (central nervous system disorder that affects movement), delirium, epilepsy, generalized muscle weakness and repeated falls.

R1's admission Minimum Data Set (MDS) assessment dated 9/29/20, indicated R1 had moderate cognitive impairment, adequate vision and hearing, clear speech, understands and was understood. R1 required extensive assistance of one staff for bed mobility, transfers and toileting and could walk in her room with limited assistance of one staff.

Following elopement on 10/6/20, R1's care plan was revised on 10/6/20 and 10/7/20, to indicate R1 was an elopement risk and staff were to observe whereabouts as R1 had periods of confusion and a tendency to wander. The care plan indicated R1 was moved to a different room and an alarm was added to her bed and chair, as well as the exit door near R1's room.

During record review, a progress noted dated 10/1/20, at 11:16 p.m. indicated staff observed R1 on the security camera unsuccessfully trying to exit the building by her room. R1 told staff she was looking for her room and got mixed up. R1 denied she was trying to leave the building. The progress note indicated R1 was having an increase in confusion around supper time since

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

admission, and the evening prior told her daughter she had to go home.

During record review, a progress note dated 10/6/20, at 4:31 a.m. indicated R1 had been checked on at midnight and 2:00 a.m. and was asleep. At 4:00 a.m. rounds, R1 was not in her room. A search for R1 ensued and she was found outside the building, lying on the ground, with her walker at the bottom of the hill. When found, staff noted "resident was in good spirits and prayed for help to arrive." R1 was assisted to a standing position, found to have scrapes to her elbows, knees, toes, fingers and temple, but denied pain. Wounds were bandaged and R1 was assisted back to bed.

According to the five-day investigative report dated 10/8/20, R1 had been sleeping in bed on 10/6/20, at 2:00 a.m. At approximately 3:30 a.m., nursing assistant (NA)-B stated she heard the alarm go off for the exit door near R1's room. NA-B looked down the hallway and did not seen any activity, but failed to investigate further. Fifteen minutes later, NA-B discovered R1 was not in her room.

During an interview on 10/12/20, at 11:03 a.m., licensed practical nurse (LPN)-A stated she was on duty the night R1 eloped. LPN-A stated NA-B and (NA)-C were doing rounds and observed R1 in her bed at midnight and 2:00 a.m. LPN-A recalls at approximately 4:00 a.m., NA-B radioed that R1 was missing. LPN-A was near the front entrance at that time, and went out the front door to look for R1 while NA-C went out the south exit, and eventually found R1. LPN-A thought the temperature outside was in the 60's and R1's arms were chilled when brought back inside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

LPN-A stated nursing staff on the evening shift were responsible to activate door alarms on the control panel at the nurses station at 9:00 p.m. each day and the night shift nurse was responsible to turn them off at 4:00 a.m. LPN-A stated she recalled seeing the lights on the alarm panel when she arrived to work, indicating they were activated.

During an interview on 10/12/20, at 11:15 a.m., R1 recalled the night she went outside, stating "I think I was dreaming" and "it wasn't a good experience." R1 further stated once she fell, she was not able to get up on her own. R1 recalled feeling chilly and added that she was trying to get back "home" (to her assisted living residence on the same campus).

During an interview on 10/12/20, at 11:40 a.m. social worker (SW)-A, who completed the Vulnerable Adult report for this incident, stated on the night of the elopement R1 exited the building at 3:30 a.m. The south exit door alarm sounded and NA-B looked down hallways, adding NA-B could not fully see R1's door due to a partition in the hallway that blocked the view. When NA-B saw no movement at the south exit door, she did not investigate further. At 3:45 a.m., R1 was discovered missing from her room. NA-C went outside to look for R1. Following the incident, R1 was moved to a different room two doors from the south exit door; staff re-education was completed, an alarm was placed on R1's bed and on the inside exit door, weekly audits of door alarm was implemented, and a verbal coaching was provided to NA-B for not for investigating why the door alarm sounded.

During a telephone interview on 10/12/20, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

12:08 p.m., NA-B stated R1 was sleeping soundly at 2 a.m. when she rounded on her. When NA-B checked on her before 4 a.m. rounds, R1 was not in her room. NA-B radioed NA-C that R1 was not in her room, and notified LPN-A. All three started searching for for R1. NA-B stated when the alarm had gone off prior to noticing R1 was not in her room (around 3:45 a.m.), she had looked down the hallway and did not see anyone. At that point NA-B shut the door alarm off to silence it, then reset it.

During a telephone interview on 10/12/20, at 12:35 p.m. family member (FM)-E stated she was informed of R1's elopement that morning. "They told me they were doing 4:00 a.m. rounds and R1 was not in her room and they found her outside." FM-E stated R1 had no prior history of wandering, but R1 had been in the hospital for six days prior to admission with a urinary tract infection and fractured ribs from a fall at home. "She wasn't herself at that point." FM-E stated the facility informed her they added a second alarm to the exit door and an alarm to R1's bed and chair to prevent reoccurrence.

During a telephone interview on 10/12/20, at 1:39 p.m., NA-C stated that night NA-B radioed her to ask if she had seen R1. NA-C said she had not heard the door alarm go off, but may have been on the second floor of the facility at that time. After NA-C checked R1's room and an empty room next to it, NA-C went out the south exit door by R1's room. NA-C did not see R1 until she went around to the back of the building and found R1 laying on the private road on the east side of the facility. R1's walker was at the bottom of the hill. NA-C stated she did not know what time R1 left the building but found R1 at approximately 4:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

a.m.

During an interview on 10/13/20, at 11:20 a.m. maintenance worker (MW)-A measured the distance from the south exit to the approximate location on the private road on the east side of the facility where NA-B found R1. This measured 62 yards.

During an interview on 10/13/20, at 11:38 a.m., the director of nursing (DON) indicated the following actions were taken after R1 eloped on 10/6/20: an alarm was added to the inside door of the south exit, a note was placed on the alarm panel indicating this door alarm was to remain on at all times, staff received education on use of alarms and responding to alarms, and NA-B received a disciplinary coaching. After the first elopement attempt on 10/1/20, DON stated they did not move R1 to a room further away from exit door, but removed R1's purse and keys from her procession, thinking it would make R1 not think about going home since she lives across the street. DON added "I guess the only other thing we could have done was to start the tab alarms sooner." DON stated a resident's elopement risk was not reassessed after an elopement or an elopement attempt; "it's only reassessed quarterly and is not currently being done if there is a new attempt to leave or elopement." DON reiterated that NA-B did not physically look for R1 on 10/6/20 and turned the alarm off to silence it, then immediately turned it back on to reset it, which was why other staff did not hear the alarm. DON stated it was her expectation all staff take door alarms seriously and fully investigate when an alarm sounds, stating it was required in order to ensure safety of the residents and staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

During an interview on 10/13/20, at 12:16 p.m., administrative support (AS)-D played the security camera footage from 10/6/20:
--3:28 a.m.: R1 is observed walking with her walker, leaving through both sets of exit doors on the south side of the building, disappearing into the dark.
--4:06 a.m.: Staff are seen coming in through the employee entrance with R1 in a wheelchair.

In addition, R1's attempt to exit the building on 10/1/20 was viewed on security camera footage:
--6:59 p.m.: R1 is seen walking with her walker, opening the first exit door. The door opens momentarily, then closes.
--7:05 p.m.: R1 is seen again attempting to push walker through exit door. The door closed, pushing R1 back into the hallway. R1 had gotten about a foot into the vestibule with her walker before the door pushed her back.

During an interview on 10/13/20, at 1:40 p.m. DON verified an elopement risk assessment completed on admission and dated 9/29/20, failed to identify whether or not R1 was an elopement risk. DON stated when a nurse completes an elopement risk assessment form, they were to document their analysis by describing and summarizing the overall risk.

During an interview on 10/13/20, at 3:00 p.m., health information manager (HIM)-C stated she was responsible for updating the document titled high risk elopement which included color photos, names and room numbers of residents deemed high risk for elopement. According to HIM-C, R1's photo was added on 10/6/20. This document was routed to all departments, and staff were to contact nursing staff if any of the residents were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

seen outside of their corridor without supervision.

R2

R2's face sheet printed 10/12/20, included diagnosis of displaced intertrochanteric fracture of left femur (fracture of hip) 5/28/20, and vascular dementia (impaired blood flow to the brain).

R2's quarterly Minimum Data Set (MDS) assessment dated 9/2/20, identified R2 has severely impaired cognition, requires extensive assistance for walking and uses a walker and wheelchair.

R2's care plan dated 3/2/20, indicated R2 had alteration in thought process r/t cognitive loss in severe range, chronic disease process and history of alcoholism with goal of R2 making appropriate informed activities of daily decisions and has potential for alteration in behavior related to cognitive loss and need for nursing home placement, inappropriate toilet habits, swears at staff with goal of being content in nursing home environment. The care plan lacked evidence regarding elopement risk and interventions for staff to ensure R2's safety.

R2's nurse progress note dated 8/2/20, at 2:20 p.m. stated at 1:30 p.m., staff were alerted to R2 heading out the front doors. Staff intervened and brought him back to nurse's station and turned television on for him. Twenty minutes later a page from staff indicated R2 was outside in wheelchair rolling toward the cement path. Staff intervened and brought R2 back to the nurse's station and reminded R2 he is was not supposed to go outside by himself and R2 agreed to sit on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

sofa and watch television.

R2's nurse progress note dated 8/8/20, at 1:38 p.m. stated certified nursing assistant (NA), left for the day and noticed R2 out on side walk in front of facility. NA brought resident back into facility and staff put him on couch.

R2's Elopement Risk Assessment dated 5/31/20, identified R2 was at low risk for elopement and was immobile. During a quarterly assessment dated 8/28/20, interventions were added for implementation indicating the resident was mobile in wheelchair and staff supervise his whereabouts. R2's elopement risk lacked mention of two previous elopement attempts on 8/2/20 and 8/9/20.

R2's CNA Flow Sheet for 8/2/20 through 8/5/20, indicated no for wandering, was blank for 8/6/20 and 8/7/20, no for 8/8/20 - 8/10/20 and blank for 8/11/20 - 8/17/20.

R2's Event reports for 8/2/20 and 8/8/20 were requested however not provided.

Reviewed departmental updates, daily interdisciplinary reports from 8/10/20 and 8/11/2020 and no mention was made of elopement attempts.

During interview on 10/12/20, at 12:25 p.m., licensed practical nurse (LPN)-A indicated R2 had attempted a few times to get out of the building. LPN-A indicated they use the door lock alarms to alert staff if a resident gets outside. Four door alarms are left on all day and include chapel, basement and one she was unable to recall and the south door, which just started recently after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

another resident was found outside. LPN-A indicated all alarms are turned on approximately 9:00 p.m. in the evenings and turned off approximately 4:00 a.m. LPN-A indicated if a resident is found outside they are added to an elopement list that is posted beside the nurse's station. R2 is currently on the list.

During interview on 10/13/20, at 9:40 a.m., NA-A indicated they check on residents more often if they have eloped but there aren't any set times to follow or forms to complete. NA-A indicated that an elopement is when someone leaves the building with intent to leave the building, but isn't an elopement if someone goes out the door looking for a closet or bathroom. NA-A notifies the charge nurse when someone elopes outside that isn't allowed to, and allowance outside is generally care planned. NA-A indicated R2 is on the list posted behind the nurses station.

During interview on 10/13/20, at 10:00 a.m., LPN-A indicated an incident report is completed if the resident is found outside if they are not allowed to alone. LPN-A further indicated R2 is not supposed to go out by himself and would consider it an elopement if R2 got outside.

During interview on 10/13/20, at 10:15 a.m., the director of nursing (DON) indicated staff will usually complete an incident report form if a resident gets outside but she also reviews the progress notes or twenty-four hour report daily. The DON further indicated interventions should be implemented following an elopement attempt, but may be added to a behavioral plan of care versus a new elopement plan of care. The DON indicated R2 was placed on the elopement list and should have been assessed as a high risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

elopement with interventions put into place.

R4

R4's face sheet printed 10/13/20, included diagnosis of dementia, and multiple sclerosis (progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord).

R4's quarterly Minimum Data Set (MDS) assessment dated 7/5/20, indicated moderately impaired cognition and required extensive assistance for walking, was independent with locomotion on unit and required extensive assistance of one for locomotion off the unit.

R4's plan of care dated 10/8/20, indicated potential for alteration in behavior related to confusion, restless, wandering, seeking exit, impulse with goal that R4 will not make attempt to leave the building.

A nurse progress note dated 7/8/20, at 5:25 p.m., indicated R4 was having increased agitation over the last week and wandering outside.

A nurse progress note dated 7/8/20, indicated at 3:30 a.m., R4 wheeled out of her room and sat in front of the main entrance doors. The licensed practical nurse (LPN) was called to another floor and the nursing assistant on the floor was in another resident room when the front door alarm sounded. The NA responded and attempted to get R4 back into the building when R4 started yelling and swearing she wasn't going back inside. The NA called the nurse on the communicator to inform her of what was happening and LPN returned to main floor to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

unlock the door to let them back into the facility.

A nurse progress note dated 7/27/20, at 3:43 p.m., indicated R4 wheeled herself outside and refused to come back in stating, "I am going home."

A nurse progress note dated 7/27/20, at 4:55 p.m., indicated "resident got outside per self twice today. Able to redirect second time."

A nurse progress note dated 9/29/20, at 8:07 p.m., indicated R4 was seen wheeling in her wheelchair down main entrance road to the first entrance to the Maple's [assisted living on campus] driveway. The registered nurse (RN) who saw her, retrieved R4 and brought her back into building to her room safely. RN notified charge nurse to complete elopement paperwork.

A social services (SS) note dated 10/2/20, at 11:34 a.m., (late entry for 9/29/20) included follow up for incident of 9/29/20. Staff had observed resident wheeling self out of the building while passing supper trays and by the time staff got to R4 she was by the Maples first driveway. Resident returned to building without incident.

R4's elopement quarterly review dated 7/5/20, indicated elopement risk assessment was reviewed with no changes in assessment. A quarterly review completed 10/4/20 indicated resident was exhibiting an increase in confusion and wanting to go home. Interventions implemented included bring to dayroom and do 1:1 activity, close fire doors and staff to do frequent checks of where about, see care plan.

Requested Incident/Accident Reports for R4 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

January 2020 through October 2020 and three were received with none related to elopement.

A Nursing Assistant Flow Sheet for August indicated no wandering behaviors were documented 9 times with 22 left blank. September flow sheet indicated yes on 9/10/20, no 13 times including 9/29/20 and blank 15 times. October flow sheet indicated yes on 10/4, no 7 times and blank 5 times.

During interview on 10/12/20, at 9:40 a.m., nursing assistant (NA)-A indicated R4 has attempted a few times to leave and is currently on the elopement list and they check on her frequently. NA-A further indicated an elopement is when someone leaves the building intentionally and if that occurs, they let the charge nurse know so necessary paper work can be completed.

During interview on 10/13/20, at 9:15, R4 indicated she has been here too long and that she has gone home before, but has never tried to go home in the middle of the night. R4 further indicated if she wants to go home, she will go home and they can't stop her from doing so.

During interview on 10/13/20, at 9:20 a.m., licensed practical nurse (LPN)-A indicated R4 has tried to elope just over the past few months, has been more confused and they check on her frequently. LPN-A indicated on 7/8/20, when R4 got outside, the NA heard the alarm, turned it off not realizing that unlocks the door. The security cameras were up on the computer and the NA saw R4 roll herself out the door and immediately went to get her. LPN-A stated frequently checks can mean every 30 minutes to four hours and there is no set protocol for staff to follow and no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

form to document checks. LPN-A indicated she will write a note at the end of the shift as to how often they checked on the resident, but is unsure what others do. LPN-A indicated R4 is on the elopement list that is distributed to all departments in case a resident would go missing.

During interview on 10/13/20, at 10:00 a.m., LPN-A indicated an incident report is completed if a resident gets outside when they shouldn't, which is care planned, and resident is placed on the elopement risk sheet. When asked if residents sign out to go outside, LPN-A indicated the sign out sheets are only for when they leave the campus with family or for appointments and not for when they just exit the building to go outside. LPN-A indicated R4 is not allowed to go outside alone and it would be considered an elopement if she got outside.

During interview on 10/13/20, at 10:15 a.m., the director of nursing (DON) indicated staff will usually complete an incident report form if a resident gets outside but she also reviews the progress notes or twenty-four hour report daily. The DON further indicated interventions should be implemented following an elopement attempt.

During interview on 10/13/20 at 11:38 a.m., the DON indicated R4 was placed on the elopement list but reassessments are currently not completed if a resident attempts to leave or elope. They are done quarterly only.

Facility policy titled Wandering Resident/Elopement, dated 5/2016, indicated the following:
1. The entire staff at the facility has the responsibility to provide security and safety for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

their resident population.
2. Nursing or social services will do an initial screening for wandering/elopement risk when gathering initial intake information.
3. During admission process each potential resident will be screened for potential of elopement risk to evaluate appropriate placement.
4. Any resident identified as "at risk for wandering or elopement" will have their picture taken on admission and share/posted with all other departments.
5. Any elopement risk assessment will be performed and care plan will be developed/reviewed/revised to ensure safety.
6. Nursing and/or social services will complete an elopement risk assessment on admission and the resident's risk will be reviewed quarterly and as needed with any significant changes. Information will be obtained from admission assessment, family, resident interviews, staff observations and social history.
7. A care plan identifying wandering and elopement risks will be implemented on admission with quarterly review as needed.
8. If a resident leaves the building without informing the staff, measures will be taken to locate and return the resident to the facility.
9. Appropriate delegation will be made to engage in the search procedures.
10. All areas will proceed to conduct a thorough search.
11. An Elopement Investigation Report will be completed. Results will be shared at Quality Assurance.

Facility policy titled Door Alarms, dated 10/6/20, indicated the following:
1. It is the policy of the facility to ensure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 safety of residents and staff with the use of door alarms. This policy will ensure proper procedure when a door alarm sounds. 2. Door alarm panel is located behind the nurses station. 3. Charge nurse is responsible for turning alarms on in the evening and off in the morning. 4. Certain doors alarms are to remain on at all times. These are posted on the alarm panel. 5. If door alarm sounds, staff are to check the panel for which door. Staff are then to check the door for any activity outside of the door. 6. Do a resident check on the hallway if no activity noted outside. The past non-compliance lJ that began on 10/6/20, was verified during the 10/12/20 - 10/14/20, onsite visit to have been corrected by the facility on 10/7/20. The verification of corrective action was confirmed by staff interviews, observations and record review. New alarms put in place were observed (door and bed), the panel alarm at the nurses' station was observed, alarm audits were reviewed. R1's photo was added to the facility high risk elopement tool. R1's care plan was updated to include new elopement interventions; staff re-education was completed and NA-B received a disciplinary coaching.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 3, 2020

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

Re: Event ID: SYX611

Dear Administrator:

The above facility survey was completed on October 14, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 10/12, 10/13 and 10/14/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint found to be substantiated:	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	C 10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H#5407014C and H#5407015C, however NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		