DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 8, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: January 7, 2021

Dear Administrator:

On January 27, 2021, we notified you a remedy was imposed. On February 22, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 9, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 11, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 27, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 7, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed 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

Electronically Submitted
January 27, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: January 7, 2021

Dear Administrator:

On January 7, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 7, 2021, the situation of immediate jeopardy to potential health and safety cited at both F600 and F610 were removed. However, continued non-compliance remains at the lower scope and severity of D for both.

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 for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 11, 2021.

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 11, 2021 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 11, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 7, 2021. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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 Sections 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 Johns On Fountain Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 7, 2021. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 1/5/21, 1/6/21, and 1/7/21, 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: H5635012C, with a deficiencies cited at F600, F609 and F610. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to protect a resident from verbal abuse when a staff person screamed at R1 and called her a liar. The survey also resulted in an IJ at F610 when the facility also failed to throughoutly investigate the incident and failed to protect R1 from further harm during the investigation. The IJs began on 12/30/20, and the immediacy was removed on 1/7/21. 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.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		2/9/21

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

Electronically Signed | 02/03/2021

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 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to protect 1 of 3 residents (R1) from verbal abuse. Verbal abuse occurred when a staff person screamed at R1 and called her a liar and the facility failed to take immediate action to protect R1 from further abuse. This finding constituted an immediate jeopardy (IJ) situation which had potential to affect all 26 residents residing on the second floor, as nursing assistant (NA)-A continued to work despite an allegation of verbal abuse towards R1. The IJ began on 12/30/20, when the facility failed to take action when R1 informed social worker (SW)-A that a staff member screamed in her face and called her a liar. The facility failed to protect R1 and other residents from continued verbal abuse from NA-A. The administrator, director of nursing (DON) and director of social services (SW)-B were informed of the IJ on 1/6/21, at 4:53 p.m. The facility implemented corrective action	F 600	F600 " R1 continues to reside at St. Johns Fountain Lake-The Woodlands. Staff have been re-educated to immediately report allegations of abuse. " All residents could be affected by the alleged practice. o Interviews have been conducted with residents and staff to assure that residents are free from abuse and neglect. No other incidents of alleged abuse or neglect were identified. " The alleged perpetrator will be removed from resident care until investigation is completed. " All allegations of abuse or neglect will be verbally communicated to the Administrator immediately and as stated in the facility□s Vulnerable Adult Policy. Licensed Nurses and Social Workers will be re-educated to verbally contact the	

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F 600	Continued From page 2 and the IJ was removed on 1/7/21, at 2:56 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's facesheet with admission date of 7/21/20, included a diagnosis of dementia without behaviors. R1's quarterly Minimum Data Set (MDS) assessment dated 12/30/20, indicated R1 was cognitively intact; had adequate vision and hearing, clear speech, was able to make herself understood and could understand others. R1 depended upon staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and hygiene. R1's plan of care, dated 7/28/20, indicated R1 had alterations in mood related to changes in a new environment. Staff were to monitor mood and report changes such as withdrawal, tearfulness and sadness. During an interview on 1/5/21, at 11:51 a.m., SW-A stated she completed R1's quarterly MDS update on 12/30/20. At the end of the interview SW-A asked R1 how staff treat her; were they gentle and respectful? R1 responded, stating she loved all the girls except one who she did not get along with. R1 told SW-A a staff member had screamed in her face and called her a liar. R1 went on to tell SW-A that she did not want her to do anything about it for fear of retaliation, adding that if she said too much, the staff person might yell at her more. R1 could not remember the staff	F 600	Administrator immediately. The Administrator is available during off hours. Nursing and Social Services staff will be reminded that the Administrator□s cell phone number is posted at every nurse□s station and that the Administrator is available 24 / 7. Reeducation will began on January 7, 2021. " All allegations of abuse or neglect will be verbally communicated to the Director of Nursing (DON) immediately. Licensed Nurses and Social Workers will be re-educated to verbally contact the DON immediately. The DON is available during off hours. Nursing and Social Services staff will be reminded that the DON□s cell phone number is posted at every nurse□s station and that the DON is available 24 / 7. Reeducation will begin on January 7, 2021. " The facility□s Vulnerable Adult Policy and Procedure was reviewed at 9am, January 7, 2021 with facility department managers and lead personnel. " Review of the facility□s Vulnerable Adult Policy with front line staff will began on January 7, 2021 and will be ongoing a. All staff will need to review the VA Policy and Procedure prior to beginning their work shift. b. Staff will need to take quiz to prove competency and sign off sheet to monitor completion " Staff will watch VA news clip that will show verbal, emotional, confinement and physical abuse that has happed in MN to show what abuse looks like. https://www.youtube.com/watch?v=8Rqi-B7rr8g	

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F 600	Continued From page 3 person's name, but described her as an older woman who worked the evening shift. Following this allegation, SW-A spoke to SW-B and registered nurse (RN)-B about the allegation. No further action was taken. During an interview on 1/5/21, at 2:21 p.m., SW-A stated as part of an abuse allegation, staff and residents were supposed to be interviewed. SW-A admitted no residents had been interviewed since R1's allegation of verbal abuse. SW-A stated 12/31/20, "was crazy" they were giving COVID-19 vaccinations and she was helping with that. SW-A stated she had wanted to talk to R1 again to get more information, but by the time she did and interviewed NA-B and (NA)-D, that was as far as she got. SW-A added more would have been done had it not been a holiday. SW-A stated she had asked NA-B, who was scheduled to work New Years Day with NA-A, to leave her a note if any concerns came up with NA-A. An email from RN-B to the DON and administrator dated 12/31/20, at 11:29 a.m. indicated R1 made an allegation of mistreatment when she was being interviewed by SW-A for her MDS and that SW-A was doing the report and investigation. SW-A notes from an interview with NA-D, dated 12/31/20, at 2:15 p.m. indicated NA-A would get a tone. If a resident was giving attitude, NA-A would get snarky. SW-A notes from interview with NA-B, dated 12/31/20, at 2:30 p.m. indicated on Christmas Eve R1 was crying because NA-A was rude and mean, and R1 got off bed pan and still had to go. NA-A said, "I'm not dealing with her." NA-B	F 600	a. Staff will sign off sheet once video has been watched to see the seriousness of abuse. " Ongoing VA training will be provided to current staff and new staff per State and Federal regulations. " Ongoing assessments will be completed by Social Services at resident care plan reviews and as needed. " Allegations of abuse and neglect will be reviewed by the Quality Assurance Committee.	

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F 600	Continued From page 4	F 600		

answered R1's call light and R1 said she had an accident because NA-A wouldn't bring her the bed pan. NA-B has reported this behavior before to RN-A, but nothing was done. NA-A would make residents do things they don't want to do. NA-A would refuse to answer R1's call light saying "I don't care what your son owns; your name means nothing to me." At the end of the interview SW-A asked NA-B to leave her a note if anything came up over the weekend in regards to NA-A.

An email from RN-A to the DON, SW-A and SW-B, dated 12/31/20, at 7:06 p.m. indicated NA-C told RN-A that R1 does not want NA-A in her room. R1 did not tell NA-C or RN-A why.

An email from SW-B to the DON, dated 1/1/21, at 10:22 a.m. indicated SW-A filed an OHFC (Office of Health Facility Complaints) report on allegations against a staff member on evening shift. The email indicated the facility was not sure who the staff was other than R1 stated it was an older lady who worked from 3 p.m. to 10 p.m.

A handwritten note from NA-B to SW-A, dated 1/1/21, and received by SW-A on 1/4/21, indicated NA-B was working on New Years day, on A-side, and around 5 PM after R1 got her supper tray dropped off by NA-A. R1 then put her call light on and before NA-B could go to 207 (R1's room), NA-A stopped NA-B and told her to go into R1's room, stating, "I can't deal with her tonight. I just brought her her tray and I'm definitely not dealing with it." When NA-B entered R1's room, R1 was worked up and crying, saying, "I try so hard to get along with that woman, but she is just horrible and full of hate." R1 then started crying because all she wanted was her

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F 600	Continued From page 5	F 600		

pillows fixed and NA-A told her she could deal with how they were. R1 went on the whole night about how upset she was because she just tries so hard to get along with NA-A but NA-A was so mean. R1 asked NA-B many times to please "never" let NA-A in her room again. This same thing happened on 12/31/20, when NA-C was working both days, and reported to RN-A as she was the nurse both nights.

During an interview on 1/5/21, at 10:53 a.m., when asked how she was treated by staff, R1 stated, "I talked to someone about it and that just causes trouble and I'm not going to cause trouble." When asked if a staff person got in her face and yelled at her, R1 stated, "I will not answer that; I've prayed that she finds happiness and completeness. My condemning her is my fault. I'm not saying more." R1 stated she did not know the staff person's name.

During the interview on 1/5/21, at 11:51 a.m., SW-A stated she confirmed with R1 on 1/4/21, at 2:30 p.m., that the staff member she had been referring to was NA-A. SW-A stated she had been standing outside R1's room when NA-A went into the room to answer the call light. After NA-A left R1's room, SW-A went in and asked R1 if NA-A was the staff person who screamed at her and called her a liar. R1 confirmed it was. SW-A informed the DON of this finding immediately following the interview with R1.

During an interview on 1/5/21, at 12:55 p.m., the DON stated it was not until 1/4/21, that she learned who the resident and the staff person were, and also became aware R1 no longer wanted NA-A in her room. DON stated she talked to NA-A on 1/4/21, at 3:30 p.m. about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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F 600	Continued From page 6	F 600		

allegation of abuse and informed her not to go into R1's room during the investigation.

During an interview on 1/5/21, at 1:54 p.m., the DON stated NA-A was one of their stronger employees who advocated for residents, therefore it was decided they would offer her the Employee Assistance Program in order to find out what was causing her to be more short than normal. The DON stated NA-A would not be suspended during the investigation.

During an interview on 1/5/21, at 3:20 p.m., the DON stated the chain of command when she was on vacation "generally starts with the NA, who tells the nurse, who tells the nurse manager, who tells me." The DON stated a nurse was responsible to take action for something like this and that RN-A should have told NA-A not to go into R1's room anymore.

During an interview on 1/6/21, at 9:52 a.m., SW-B presented the facility PowerPoint used for staff training in 2020, titled, Freedom from Abuse, Neglect, Misappropriation and Exploitation for Direct Caregivers. SW-B stated she taught the training and that the training indicated they did not have to take an employee off the schedule - it depended upon the allegation. SW-B went on to say that it was automatic to remove an employee from the schedule if there was bodily harm. SW-B added, they would take into consideration if the employee was "good staff; if complimented by other residents, family and staff -- even if staff say she's snippy." Further, SW-B stated staff should have told them what was going on as they are responsible to inform someone when they see abusive behaviors by a coworker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 7	F 600		

During an interview on 1/6/21, at 12:08 p.m., the administrator stated he first learned of the allegation of verbal abuse on 1/4/21, when SW-B sent him an email message. The administrator stated he was in the facility on 12/30/20, and 12/31/20, but had not been informed of the allegation of abuse. The administrator was handed an email dated 12/31/20, time of 11:29 a.m. which included him, and which read: R1 made an allegation of mistreatment when she was being interviewed by [SW-A] for her MDS. [SW-A] is doing the report and investigation. The administrator stated he did not recall seeing this email, adding, "I completely missed it; I was here that day." The administrator stated they would normally take an employee off the schedule or at least not have them working with that resident. The administrator said they would honor the resident's wishes. The administrator stated if he had seen the email, he would have taken NA-A off the schedule or at a minimum, would not have allowed NA-A to go into R1's room.

During an interview on 1/6/21, at 3:35 p.m. NA-A stated SW-A informed her of R1's allegation on 1/4/21, adding, "I was taken aback by that." NA-A stated she never called R1 a liar or yelled at her. NA-A did not know why R1 would say that. NA-A went on to say, "I speak loudly, so does she think I'm yelling?" NA-A thought maybe R1 called her a liar when R1 requested something for supper, then said she did not request it. When NA-A pointed that out to R1, R1 asked if NA-A was calling her a liar. NA-A denied feeling frustrated or short on temper when caring for residents, adding, "I come across as harsh or stern, I am matter of fact." R1 denied having asked coworkers to answer R1's call lights for her when she cannot deal with R1 anymore. NA-A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 600	Continued From page 8	F 600		

the DON informed her of the allegation of abuse against her on 1/4/21, at about 3:30 p.m., and to not to go into R1's room. NA-A stated she had already been in there two or three times as she did not know.

During an interview on 1/6/21, at 5:59 p.m., RN-A stated she emailed the DON, SW-A and SW-B on 12/31/20, that (NA)-D said R1 did not want NA-A in her room, but R1 did not say why, and RN-A admitted she did not ask R1 why. RN-A stated that NA-B told her the same thing on New Years Day, and she informed NA-B she had already reported it. RN-A stated they were not able to keep NA-A out of R1's room completely, as she was needed to help with two-person cares. RN-A did not feel it was her responsibility to tell NA-A that she should not go into R1's room, stating that should come from a social worker. SW-A notes from interview with NA-C, dated 1/4/21, indicated: NA-A was pretty mean to R1; NA-A would not jump up to answer her call light. R1 told NA-C she does not want NA-A in her room. NA-A has voiced to NA-C that she does not like R1 because NA-A believes R1 expects special treatment.

Staff schedules were reviewed and the DON confirmed NA-A worked on the following shifts: 12/30/20, 12/31/20, 1/1/21, 1/4/21, 1/5/21, 1/6/21; all 2 p.m. to 10 p.m. shifts.

During a telephone interview on 1/8/21, at 14:42 p.m., family member (FM)-A stated R1's care was "really good, except for an older gal" whose name FM-A did not know. FM-A stated it was likely a personality clash, adding the staff person was a hard worker, but did not have a tender bedside manner. Further, FM-A stated the tone of her voice was not as sweet as other staff and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 600	Continued From page 9	F 600		

was not as patient, but had never detected anything malicious or mean. FM-A stated a couple of weeks prior to Christmas, that would be the first thing R1 said when they called her -- that she dreaded when this staff person worked. FM-A stated they did not report it to the facility, but were at the point where they were going to because R1 kept telling them the same thing every time they talked to her.

The facility policy titled, Reportable Incidents Policy, revised date 8/27/20, indicated the following definitions:
--Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including care taker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful means the individual's act was deliberate -- not inadvertent or accidental -- regardless of whether or not the individual intended to inflict injury or harm.
--Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gesture communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident, with the intent to intimidated, threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends, and isolating a resident from social interaction or activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 600	Continued From page 10	F 600		

The facility's undated PowerPoint slide deck used in 2020, for staff training on abuse titled: Freedom from Abuse, Neglect, Misappropriation and Exploitation indicated:
1. Objectives: to protect residents from abuse and identifying abuse.
2. Regulations: residents have the right to be free from abuse. The facility must promote resident rights.
3. Role and responsibilities of staff to step in to assist others who may be frustrated or angry.
4. Definition of abuse, including verbal abuse.
5. Examples of abuse, including verbal abuse.
6. If you witness or are informed of abuse, you must first protect the resident, intervene and stop the abuse.
7. Preventing further abuse: the facility must protect the residents from further abuse while the investigation is being completed.
8. Direct care givers are required to follow nursing home regulations.
9. Healthcare workers are required to identify and report alleged abuse.

The immediate jeopardy that began on 12/30/20, was removed on 1/7/21, at 2:56 p.m., when the facility developed and implemented interventions to ensure all allegations of abuse or neglect were verbally communicated to the administrator and DON immediately. Licensed nurses and social workers were re-educated on this, and were reminded that the administrator and DON are available 24/7 and their cell phone numbers were posted at every nurses station. Five residents were interviewed on 1/6/21, and findings were reported to the administrator, DON, and social workers. The facility VA policy and procedure was reviewed with department managers, lead personnel and front line staff. The administrator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 600	Continued From page 11 DON, social services and nurse managers conducted a table top exercise on 1/7/21, to review the VA policies and procedures. Going forward, two or more members of the leadership team (administrator, DON, social workers and nurse managers) will convene a meeting immediately upon report of alleged abuse or neglect. The purpose of the meeting is to assure the residents(s) are protected and that facility policies, procedures, State and Federal requirements are being followed. This practice was added to the facility VA policy and procedure document. The Quality Assurance Committee will review all reported cases of abuse and neglect. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		2/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 609	Continued From page 12 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse/neglect were reported to the administrator and State Agency (SA) within two hours, in accordance with established policies and procedures, for 1 of 3 residents (R1) reviewed for allegations of staff to resident abuse. Findings include: R1's facesheet with admission date of 7/21/20, included a diagnosis of dementia without behaviors. R1's quarterly Minimum Data Set (MDS) assessment dated 12/30/20, indicated R1 was cognitively intact; had adequate vision and hearing, clear speech, was able to make herself understood and could understand others. R1 depended upon staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and hygiene. R1's plan of care, dated 7/28/20, indicated R1 had alterations in mood related to changes in a new environment. Staff were to monitor mood	F 609	F609 " R1 continues to reside at St. Johns Fountain Lake-The Woodlands. Staff have been re-educated to immediately report allegations of abuse neglect, exploitation, or mistreatment to the Administrator, Director of Nursing, the State Survey Agency, and protective services. " All residents could be affected by the alleged practice. " All allegations of abuse or neglect will be verbally communicated to the Administrator immediately and as stated in the facility□s Vulnerable Adult Policy. Licensed Nurses and Social Workers will be re-educated to verbally contact the Administrator immediately. The Administrator is available during off hours. Nursing and Social Services staff will be reminded that the Administrator□s cell phone number is posted at every nurse□s station and that the Administrator is available 24 / 7. Reeducation will begin on January 7, 2021. " All allegations of abuse or neglect will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 609	Continued From page 13 and report changes such as withdrawal, tearfulness and sadness. During an interview on 1/5/21, at 11:51 a.m., when SW-A completed R1's quarterly MDS update on 12/30/20, she asked R1 how staff treat her; were they gentle and respectful? R1 responded, stating she loved all the girls except one who she didn't get along with. R1 told SW-A a staff member had screamed in her face and called her a liar. R1 went on to tell SW-A that she did not want her to do anything about it for fear of retaliation, adding that if she said too much, the staff person might yell at her more. R1 couldn't remember the staff person's name, but described her as an older woman who worked the evening shift. Following this allegation, SW-A spoke to (SW)-B and registered nurse (RN)-B about it. SW-A confirmed that neither the DON or the administrator were notified. During an interview on 1/5/21, at 2:21 p.m., SW-A stated she started a report to the SA on 12/30/20, and finished it on 12/31/20. SW-A stated she needed more information to submit the initial report and R1 wasn't giving to her; therefore she saved the report on 12/30/20 and finished it on 12/31/20. During an interview on 1/6/21, at 9:52 a.m., SW-B, stated the facility had 24 hours to report the allegation of verbal abuse since there was no bodily injury, therefore they decided to wait until the next day. SW-B stated SW-A wanted more information before she filed the report to the SA. When asked if the administrator was present in the facility on 12/30/20, SW-B stated he was, and should have been notified as soon as possible about the allegation of verbal abuse, adding "it	F 609	be verbally communicated to the Director of Nursing (DON) immediately. Licensed Nurses and Social Workers will be re-educated to verbally contact the DON immediately. The DON is available during off hours. Nursing and Social Services staff will be reminded that the DON□s cell phone number is posted at every nurse□s station and that the DON is available 24 / 7. Reeducation will begin on January 7, 2021. " Two or more members of the leadership team will convene a meeting immediately upon report of alleged abuse or neglect. The purpose of the meeting is to assure that the resident(s) are protected and to assure that facility policies, procedures, and state and federal requirements are being followed, including reporting requirements. o This practice was updated and added to the facility□s VA Policy and Procedure document. o The leadership team will consist of the following disciplines: Administrator, Director of Nursing, Social Services Department and Nurse Managers. " A VA Tabletop Review scheduled for January 7, from 9:45am to 11:30am, to review the VA Policies and Procedures and to make changes if necessary. The following disciplines participated in the Tabletop Review: Administrator, DON, Social Services, and Nurse Managers. o Administrator, DON and Social Service contact information was added to front of VA Policy and Procedure book for easy access to phone numbers. " The facility□s Vulnerable Adult Policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 609	Continued From page 14 was my bad." During the same interview, SW-B presented the facility PowerPoint used for staff training in 2020, titled Freedom from Abuse, Neglect, Misappropriation and Exploitation for Direct Caregivers. SW-B stated she taught the training and the training indicated staff should have told them what was going on as they were responsible to inform someone when they saw abusive behaviors by a coworker. The training also included slides indicating staff were to report all alleged abuse immediately to the administrator and state agency within 2 hours and were to make an immediate oral report to the supervisor, administrator, DON, or social services when there was reason to believe a resident was being or had been abused. SW-B reiterated that since there wasn't bodily injury, the facility had 24 hours to report to the SA. During a telephone interview on 1/6/21, at 11:15 a.m., former RN-B stated she was made aware of the abuse allegation on 12/30/20, at approximately 9:30 a.m. by SW-A. The plan of action was discussed, and SW-A stated she would report it to the SA. RN-B stated she did not report or discuss the concern with anyone else. RN-B stated that on 12/31/20, she sent an email to the DON and administrator about the allegation, but admitted she didn't speak to either one directly. During an interview on 1/6/21, at 11:45 a.m., the DON stated she thought the facility followed their abuse prevention policy appropriately in this case. The facility reportable incidents policy was handed to the DON with attention shown to the time frame for reporting alleged violations. DON	F 609	and Procedure was reviewed at 9am, January 7, 2021 with facility department managers and lead personnel. " Review of the facility□s Vulnerable Adult Policy with front line staff began on January 7, 2021 and will be ongoing. o All staff will need to review the VA Policy and Procedure prior to beginning their work shift. o Staff will need to take quiz to prove competency and sign off sheet to monitor completion. " The Quality Assurance Committee will review all reported cases of abuse and neglect. o The Quality Assurance Committee consists of the following disciplines: Administrator, Director of Nursing, Social Service Department, Nurse Managers, Contracted Pharmacist, Medical Director and Staff Development/Infection Prevention Nurse. " Re-education to licensed nurses on how to submit an OHFC report will be conducted and will continue with new hires of licensed nurses and be ongoing. This will allow timely notification to state agencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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F 609	Continued From page 15	F 609		

stated since there wasn't bodily harm, they wouldn't have to report in two hours. After reading the policy further, the DON admitted that the allegation of verbal abuse should have been reported, stating "yeah, it should have been reported in two hours."

During an interview on 1/6/21, at 12:08 p.m., the administrator stated he first learned of the allegation of verbal abuse on 1/4/21, when SW-B sent him an email message. The administrator stated he was in the facility on 12/30/20 and 12/31/20, but had not been informed of the allegation of abuse. The administrator was handed an email dated 12/31/20, time of 11:29 a.m. which included him, and which read: R1 made an allegation of mistreatment when she was being interviewed by SW-A for her MDS. SW-A is doing the report and investigation. The administrator stated he did not recall seeing the email, adding "I completely missed it I was here that day."

During an interview on 1/6/21, at 5:59 p.m., RN-A stated when there were concerns to report, she usually went to the nurse manager, social services or the DON. "I didn't think there was physical harm, so I didn't report it." RN-A added that she should have called the DON, as she is usually available by phone, but she had been on vacation. RN-A stated there was paperwork to start for abuse, but she didn't think any abuse occurred, adding "I should have started the paperwork."

The facility policy titled Reportable Incidents Policy, revised date 8/27/20, indicated all alleged violations involving abuse are reported immediately, but not later than two hours after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 609	Continued From page 16	F 609		

allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse, and do not result in serious bodily injury, to the administrator of the facility (or designee) and to the State Survey Agency. The policy also indicated staff were required to make an immediate oral report to the supervisor, administrator, DON or social services when there was reason to believe a resident was being or had been abused. The policy also directed staff where to refer to a phone list if the administrator or DON were not in the building. If neither the administrator or DON could be reached, staff were to report the incident on the MDH (Minnesota Department of Health) Nursing Home Incident Reporting website.

The policy included the following definitions:
--Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including care taker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful means the individual's act was deliberate -- not inadvertent or accidental -- regardless of whether or not the individual intended to inflict injury or harm.
--Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gesture communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: harassing a resident, mocking, insulting, ridiculing, yelling or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 609	Continued From page 17 hovering over a resident, with the intent to intimidated, threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends, and isolating a resident from social interaction or activities. An undated PowerPoint slide deck used in 2020, for staff training on abuse titled: Freedom from Abuse, Neglect, Misappropriation and Exploitation indicated: 1. Definition of abuse, including verbal abuse. 2. Examples of abuse, including verbal abuse. 3. If staff witness or are informed of abuse, they must first protect the resident, intervene and stop the abuse. 4. All alleged abuse must be reported immediately to the administrator and state agency within 2 hours (ex, abuse). 5. Staff are required to make an immediate oral report to the supervisor, administrator, DON, or social services when there is reason to believe a resident is being or has been abused. 6. Any and all allegations of abuse must be reported immediately. If staff are unsure, they should always report; the VA (vulnerable adult) committee will make the final decision. 7. ALL incidents must be reported immediately to the administrator or DON. If after hours or weekend call the administrator, if no answer, call the DON. 8. Direct care givers are required to follow nursing home regulations. 9. Healthcare workers are required to identify and report alleged abuse.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		2/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 610	Continued From page 18 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a thorough investigation was completed and adequate protection provided to ensure freedom from abuse for 1 of 3 residents (R1). These findings constituted an immediate jeopardy (IJ) situation which had potential to affect all 26 residents residing on the second floor, as nursing assistant (NA)-A continued to work despite an allegation of verbal abuse. The IJ began on 12/30/20, when the facility failed to take action when R1 reported an allegation of verbal abuse to social worker (SW)-A that a staff member screamed in her face and called her a liar. The facility failed to report and investigate this allegation, and to protect R1 and other residents from continued verbal abuse from NA-A. The administrator, director of nursing	F 610	F610 " R1 continues to reside at St. Johns Fountain Lake-The Woodlands. Staff have been re-educated to immediately report allegations of abuse. " All residents could be affected by the alleged practice. " All allegations of abuse or neglect will be verbally communicated to the Administrator immediately and as stated in the facility□s Vulnerable Adult Policy. Licensed Nurses and Social Workers will be re-educated to verbally contact the Administrator immediately. The Administrator is available during off hours. Nursing and Social Services staff will be reminded that the Administrator□s cell phone number is posted at every nurse□s station and that the Administrator is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 610	Continued From page 19 (DON) and director of social services (SW)-B were informed of the IJ on 1/6/21, at 4:53 p.m. The facility implemented corrective action and the IJ was removed on 1/7/21, at 2:56 p.m. However, non-compliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's facesheet with admission date of 7/21/20, included a diagnosis of dementia without behaviors. R1's quarterly Minimum Data Set (MDS) assessment dated 12/30/20, indicated R1 was cognitively intact; had adequate vision and hearing, clear speech, was able to make herself understood and could understand others. R1 depended upon staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and hygiene. R1's plan of care, dated 7/28/20, indicated R1 had alterations in mood related to changes in a new environment. Staff were to monitor mood and report changes such as withdrawal, tearfulness and sadness. During an interview on 1/5/21, at 11:51 a.m., SW-A stated that when she completed R1's quarterly MDS update on 12/30/20, she asked R1 how staff treat her; if staff were gentle and respectful. R1 stated she loved all the girls except one who she didn't get along with. R1 told SW-A a staff member had screamed in her face and called her a liar. R1 went on to tell SW-A that she did not want her to do anything about it for fear of	F 610	available 24 / 7. Reeducation will begin on January 7, 2021. " Staff were educated on January 7, 2021 to report all allegations of abuse and neglect. " The alleged perpetrator for suspected abuse or neglect will be removed from resident care until investigation is completed. " Two or more members of the leadership team will convene a meeting immediately upon report of alleged abuse or neglect. The purpose of the meeting is to assure that the resident(s) are protected and to assure that facility policies, procedures, and state and federal requirements are being followed, including investigation requirements. a. This practice will be added to the facility□s VA Policy and Procedure document. b. The leadership team will consist of the following disciplines: Administrator, Director of Nursing, Social Services Department and Nurse Managers. " Instruction will be provided to staff from a member of the leadership team to initiate the Initial Investigation form and obtain statements from any witnesses. " Interviews will be conducted with other residents/staff to obtain information for potential risk for additional abuse or neglect to other residents. " A Table Top Review was conducted January 7, from 9:45am to 11:30am, to review the VA Policies and Procedures. Updates and changes were made. a. The following disciplines participated in the Tabletop Review: Administrator,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007**

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F 610	Continued From page 20	F 610		

retaliation, adding that if she said too much, the staff person might yell at her more. R1 couldn't remember the staff person's name, but described her as an older woman who worked the evening shift. Following this allegation, SW-A spoke to SW-B and registered nurse (RN)-B about it. SW-A also talked to the staff scheduler and obtained names of staff who worked on second floor in order to determine which staff worked with R1. No further action was taken.

In a handwritten note from nursing assistant (NA)-B to SW-A, dated 1/1/21, NA-B wrote that on 1/1/21, she worked with NA-A. During the shift, NA-B entered R1's room and found R1 crying. R1 told NA-A, "I try so hard to get along with NA-A, but she is just horrible and full of hate." NA-B stated R1 was upset the entire night, telling NA-B she tried to get along with NA-A, but NA-A was so mean. R1 asked NA-B multiple times to not let NA-A in her room again. NA-B reported this to registered nurse (RN)-A.

During an interview on 1/5/21, at 10:53 a.m., when asked how she was treated by staff, R1 stated "I talked to someone about it and that just causes trouble and I'm not going to cause trouble." When asked if a staff person got in her face and yelled at her, R1 stated "I will not answer that; I've prayed that she finds happiness and completeness. My condemning her is my fault. I'm not saying more." R1 stated she did not know the staff persons name.

During the interview on 1/5/21, at 11:51 a.m., SW-A stated she confirmed with R1 on 1/4/21, at 2:30 p.m., that the staff member she had been referring to was NA-A. SW-A stated she had been standing outside R1's room when NA-A went into

DON, Social Services, and Nurse Managers.
b. Ongoing review of policy and procedure will be conducted as needed and updated as deemed appropriate.
" Findings of the investigation will be reviewed by the Administrator, Director of Nursing, and the Director of Social Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 610	Continued From page 21	F 610		

the room to answer the call light. After NA-A left R1's room, SW-A went in and asked R1 if NA-A was the staff person who screamed at her and called her a liar. R1 confirmed it was. SW-A informed the DON of this finding immediately following the interview with R1.

During an interview on 1/5/21, at 12:55 p.m., when asked what she knew about R1's allegation of abuse, the DON stated she was on vacation at the time the allegation was made, and while she did not know the details, was aware a staff member had yelled at a resident. The DON first learned the facility filed a report with the State Agency (SA) on 12/31/20, when she came to the facility for a Covid-19 vaccination. The DON stated RN-B told her a resident was not happy, but did not know who the involved staff member was at that time. The DON stated it was not until 1/4/21, that she learned who the resident and the staff person were, and also became aware R1 no longer wanted NA-A in her room. The DON stated she and the administrator planned to meet with SW-A to discuss an action plan, adding she did not want to make harsh decisions without further information. The DON stated they assumed the alleged perpetrator was NA-A, and NA-A was aware of the allegation against her. DON stated she talked to NA-A on 1/4/21, at 3:30 p.m. about not going into R1's room during the investigation, adding that NA-A did not seem too surprised.

During an interview on 1/5/21, at 1:54 p.m., the DON stated NA-A was one of their stronger employees who advocated for residents, therefore it was decided they would offer her the Employee Assistance Program in order to find out what was causing her to be more short than normal. The DON stated NA-A would not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 610	Continued From page 22	F 610		

suspended during the investigation, but would avoid working with R1. Furthermore, the DON stated they determined RN-A would receive a disciplinary warning for sending an email to the DON on 12/31/20, who was on vacation, rather than calling the administrator to inform him that R1 did not want NA-A in her room anymore. The DON stated other residents had not been interviewed to determine if there were additional concerns of verbal abuse.

During an interview on 1/5/21, at 2:21 p.m., SW-A stated as part of an abuse allegation, staff and residents were supposed to be interviewed. SW-A admitted no residents had been interviewed since R1's allegation of verbal abuse. SW-A stated 12/31/20, "was crazy" they were giving COVID-19 vaccinations and she was helping with that. SW-A stated she had wanted to talk to R1 again to get more information, but by the time she did and interviewed NA-B and (NA)-D, that was as far as she got. SW-A added more would have been done had it not been a holiday. SW-A stated she had asked NA-B, who was scheduled to work New Years Day with NA-A, to leave her a note if any concerns came up with NA-A.

During an interview on 1/6/21, at 9:52 a.m., SW-B stated it was imperative to ask other residents if they encountered the same thing R1 experienced. SW-B confirmed no resident interviews had been conducted since R1's allegation of abuse on 12/30/20. SW-B stated staff would be removed from the schedule for an allegation of bodily injury, but since there was no bodily injury in this incidence, NA-A was left on the schedule and told not to go into R1's room. When asked how other residents were protected during the investigation, SW-B stated, "we didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 610	Continued From page 23	F 610		

talk about it -- it was a holiday and no one was here." SW-B stated they should have had a discussion about removing NA-A from the schedule but did not talk about it until the morning of 1/4/21. When asked if the administrator was present in the facility on 12/30/20, SW-B verified that he was and should have been notified as soon as possible about the allegation of verbal abuse, adding, "it was my bad."

During the same interview, SW-B presented the facility PowerPoint used for staff training in 2020, titled Freedom from Abuse, Neglect, Misappropriation and Exploitation for Direct Caregivers. SW-B stated she taught the training and that the training indicated they didn't have to take an employee off the schedule - it depended upon the allegation. SW-B stated as they got more into the investigation, they obtained information from other staff about NA-A, adding, there may have been other residents NA-A had done things to.

During a telephone interview on 1/6/21, at 11:15 a.m., former RN-B stated she was made aware of the abuse allegation on 12/30/20, at approximately 9:30 a.m. by SW-A. The plan of action was discussed, and SW-A stated she would write the report, send it to the SA and do the investigation. RN-B stated she did not report or discuss the concern with anyone else. RN-B stated that on 12/31/20, she sent an email to the DON and administrator about the allegation, but admitted she didn't speak to either one directly.

During an interview on 1/6/21, at 11:45 a.m., the DON stated she thought the facility followed their abuse prevention policy appropriately in this case, however had she been at the facility, would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE 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 610	Continued From page 24	F 610		

continued the investigation on 12/31/20. The DON added that SW-A was new and did not have a lot of support for the investigation. The DON admitted she did not know if resident interviews had been done.

During an interview on 1/6/21, at 12:08 p.m., the administrator stated he first learned of the allegation of verbal abuse on 1/4/21, when SW-B sent him an email message. The administrator stated he was in the facility on 12/30/20 and 12/31/20, but had not been informed of the allegation of abuse. The administrator was handed an email dated 12/31/20, time of 11:29 a.m. which included him, and which read: R1 made an allegation of mistreatment when she was being interviewed by SW-A for her MDS. SW-A was doing the report and investigation. The administrator stated he did not recall seeing this email, adding, "I completely missed it; I was here that day."

An email from RN-B to the DON and administrator on 12/31/20, at 11:29 a.m. indicated R1 made an allegation of mistreatment when she was being interviewed by SW-A for her MDS. SW-A would be doing the report and investigation.

An email from RN-A to the DON, SW-A and SW-B, dated 12/31/20, at 7:06 p.m. indicated NA-C passed onto RN-A that R1 did not want NA-A in her room. She did not tell NA-C or me why.

An an email from SW-B to the DON, dated 1/1/21, at 10:22 a.m. indicated SW-A filed an OHFC (Office of Health Facility Complaints) report on allegations against a staff member on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE 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 610	Continued From page 25	F 610		

evening shift but they were not sure who the staff is other than R1 states it is an older lady who works from 3 p.m. to 10 p.m.

Staff schedules indicated, and DON confirmed, that NA-A worked on the following shifts: 12/30/20, 12/31/20, 1/1/21, 1/4/21, 1/5/21, 1/6/21; all 2 p.m. to 10 p.m. shifts.

The facility policy titled Reportable Incidents Policy, revised date 8/27/20, indicated the following definitions:
--Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including care taker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful means the individual's act was deliberate -- not inadvertent or accidental -- regardless of whether or not the individual intended to inflict injury or harm.
--Verbal abuse: may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gesture communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident, with the intent to intimidated, threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends, and isolating a resident from social interaction or activities.

The facility's Appendix C: Abuse Prevention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	1771 EAGLE VIEW CIRCLE 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 610	Continued From page 26	F 610		

Policy & Plan, dated 8/13/15, indicated investigations would begin with the supervising staff on duty at the time of the report and includes the nurse manager, social worker, director of nursing, the administrator and human resource director as needed. If an alleged perpetrator was identified as an employee, immediate action must be taken by the supervisor on duty to protect the resident. This may include suspension of the employee pending the results of the investigation. When a complaint was substantiated, the facility shall identify corrective actions to be taken along with a plan to minimize the risk of abuse.

The facility's Appendix J: Internal Investigation Form, dated 8/13/15, indicated the following information was to be obtained:
--Written summary of incident as described by the mandated reporter
--Written summary of incident as described by the witness(es)
--Written summary of incident as described by the resident
--Written summery of incident described by the residents family or visitors
--Summary of interview with resident roommate if applicable
--Relevant polices and procedures reviewed
--Alleged perpetrators personnel file reviewed

The facility's undated PowerPoint slide deck used in 2020, for staff training on abuse titled: Freedom from Abuse, Neglect, Misappropriation and Exploitation indicated:
1. Every allegation of abuse must be thoroughly investigated. Residents, employees, family members, visitors, and others may be interviewed about their knowledge of events.
2. The facility must protect the residents from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS ON FOUNTAIN LAKE	**1771 EAGLE VIEW CIRCLE 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 610	Continued From page 27	F 610		

further abuse while the investigation is being completed.
3. Direct care givers are required to follow nursing home regulations.

The immediate jeopardy that began on 12/30/20, was removed on 1/7/21, at 2:56 p.m., when the facility suspended the alleged perpetrator effective 1/6/21, pending further investigation, developed and implemented interventions to ensure all allegations of abuse or neglect were verbally communicated to the administrator and DON immediately. Licensed nurses and social workers were re-educated, and reminded the administrator and DON are available 24/7 and their cell phone numbers were posted at every nurses station. Five residents were interviewed on 1/6/21, and findings were reported to the administrator, DON, and social workers. The facility VA policy and procedure was reviewed with department managers, lead personnel and front line staff. The administrator, DON, social services and nurse managers conducted a table top exercise on 1/7/21, to review the VA policies and procedures. Going forward, two or more members of the leadership team (administrator, DON, social workers and nurse managers) will convene a meeting immediately upon report of alleged abuse or neglect. The purpose of the meeting is to assure the residents(s) are protected and that facility policies, procedures, State and Federal requirements are being followed. This practice was added to the facility VA policy and procedure document. The Quality Assurance Committee will review all reported cases of abuse and neglect. However, non-compliance remained at the lower scope and severity of a D, which indicated no actual harm with potential for more than minimal harm that is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 01/07/2021

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(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 610	Continued From page 28 not immediate jeopardy.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2021

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: Event ID: EWIU11

Dear Administrator:

The above facility survey was completed on January 7, 2021 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
	31639	A. BUILDING: _____ B. WING _____	C 01/07/2021

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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 1/5/21, through 1/7/21, 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 was found to be SUBSTANTIATED: H5635012C.	2 000		

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

Electronically Signed | 02/03/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 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		