DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
February 10, 2022

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

RE: CCN: 245635
Cycle Start Date: December 28, 2021

Dear Administrator:

On February 4, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Electronically delivered
January 11, 2022

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

RE: CCN: 245635
Cycle Start Date: December 28, 2021

Dear Administrator:

On December 28, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an E tag), i.e., the plan of correction should be directed to:

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 28, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 28, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245635 | A. BUILDING _____ B. WING _____ | C 12/28/2021 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>On 12/28/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be SUBSTANTIATED: H5635029C (MN79182), with deficiency cited at F684.<br><br>The following complaint was found to be UNSUBSTANTIATED: H5635028C (MN79590).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. | F 684 | | 1/27/22 |

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

Electronically Signed | 01/19/2022

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 684 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide catheter care and skin care timely for 1 of 1 resident (R2) who's catheter was malfunctioning and required changing.<br><br>Findings include:<br><br>Review of a vulnerable adult (VA) report submitted on 12/9/21, at 11:14 a.m. indicated R2 called for staff assistance on 12/6/21, at 1:45 p.m., because his catheter was leaking. The report indicated nurse manager (NM)-A informed R2 the catheter could not be changed, because there were not enough staff. NM-A indicated it took 3 staff assistance to transfer R2 into bed, with a mechanical lift. NM-A told R1 he would have to wait until an evening shift staff person arrived at around 3:50 p.m. NM-A stated R2 sat in wet clothing and a leaking catheter for 2 hours and 15 minutes, before he was assisted into bed and changed.<br><br>R2 was admitted on 4/6/21, with diagnosis (found on the face sheet in the medical record) that included; quadriplegia (paralysis of all 4 limbs) urinary tract infection (UTI) type 2 diabetes mellitus (disease that results in too much sugar in the blood) neuromuscular dysfunction of the bladder (lacks bladder control due to spinal cord problems) obesity and bladder cramps/spasms.<br><br>Review of a quarterly minimum date set (MDS) assessment, dated 12/22/21, identified R2 as having a brief interview for mental status (BIMS) of "15" (meaning cognitively intact cognition). The MDS indicated R2 was dependent on staff with | F 684 | F684<br><br>Resubmission-1-27-2022<br><br>1. Nursing staff have been assigned review of urinary catheter care skills, insertion and specimen collection (male and female) procedure.<br>2. Nursing staff have been assigned competencies for urinary catheter care skills, insertion, specimen collection 3. Deadline for completion of February 11, 2022 4. Urinary catheter audits will be completed by Nurse Managers - 1 per week until 100% compliance for four weeks.<br><br>The date that deficiencies were corrected was 1.12.2022. All residents within the facility could have the potential to be affected.<br><br>Nurse Manager and DON met with staff nurse to discuss resident rights and the needs of the resident come first. Coaching on proper communication with residents  putting their needs first as well as coaching on how to manage scheduled appointments during approved shifts was done. (Nurse should not schedule appointments when scheduled to work if at all possible. If absolutely necessary, communication and a staffing | |

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| F 684 | Continued From page 2<br>activities of daily living (ADL's) except for eating. The MDS indicated R2 has upper and lower functional limitations in range of motion (ROM). The MDS indicated R1 has an indwelling foley catheter and a diagnosis of a neurogenic bladder.<br><br>Review of a bladder assessment dated 9/29/21, identified R2 as having a suprapubic catheter, and requires staff assitance to manager the catheter. R2 has a diagnosis of a neurogenic bladder that makes it medically necessary to have a catheter. R2 is totally dependent of 2-3 staff with all transfers and toileting.<br><br>Review of the current plan of care dated 10/12/21, identified R2 as having impaired physical mobility and quadriplegic. R2 requires a mechanical lift for transfers and 2-3 staff assistance, for safety and support during transfer. R2 requires total assist with mobility, that includes turning and repositioning every 2 hours. The care plan identified R2 as having an indwelling catheter and is at risk for complications. Interventions included; provide catheter care, remain clean and dry, change catheter as needed for blockage or malfunction, call light available and answered promptly.<br><br>Review of the progress notes dated 12/5/21 to 12/28/21, did not include any documentation related to the VA filed on 12/9/21, when R2's catheter was malfunctioning/leaking urine, causing R2 to sit in urine soaked pants for 2.5 hours.<br><br>Interview on 12/28/21, at 11:30 a.m. the facility director of nursing (DON) stated she was not aware of all the details surrounding the incident with R2. The DON indicated nurse manager | F 684 | plan must be addressed at the beginning of the shift.)<br>Additional steps are being taken to expedite securing lift equipment to assist with residents with increasing lift (assistance) needs. An Arjo (Maxi Move) lift device has been requested and ordering/securing this device is a facility priority to aid in transfers of special needs residents.<br>Arjo Maxi Move power patient lift is designed to allow a single caregiver to handle difficult resident transfers as well as repositioning tasks. It is a versatile device with a variety of spreader bars to accommodate the unique needs of each resident. Provides for stable lifting and precision transfers □ reducing the need for human handling.<br>No staff will leave the unit with a known resident need without informing the charge nurse and/or Nurse Manager to assume responsibility (this was in place at the time of the deficiency but will be reinforced with staff and leadership).<br><br>Any on duty staff who have planned early departure from work hours will inform all on duty team members of this with shift report and will notify team lead/Nurse Manager as well (at the beginning of shift) to insure accuracy of number of staff on duty at all times. This includes discussion of how to manage change of shift if a double shift across campuses is involved.<br><br>Nursing staff from other areas (floors and administrative offices) will be contacted when necessary. (Practice has been and | |

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| F 684 | Continued From page 3<br>(NM)-A filed the VA report and conducted the investigation. The DON confirmed NM-A and the 2 nursing assistants (NA's) working on the unit could have assisted R2. The DON verified there were other staff on other units that could have been asked to monitor the floor, while R2 was being taken care of. The DON also indicated, R2 should not have had to wait for 2 hours and 15 minutes for staff to have his catheter changed or his soiled clothing changed.<br><br>Interview on 12/28/21, at 12:00 p.m. NM-A stated she was the nurse manager working on 12/6/21, at the time of the incident. NM-A stated R2 asked for assistant at 1:45 p.m. to have his catheter changed, because it was leaking urine on his clothing. NM-A indicated it took 3 staff to transfer R2, and there were only 2 NA's on the floor. NM-A stated she told R2 there would be enough staff to assist with transferring him to bed at 4:00 p.m. NM-A indicated R2 was not happy about having to wait. NM-A verified R2 did have wet pants and that the catheter was leaking. NM-A confirmed there were 3 staff that could have assisted R2 into bed, but there was no one to watch the other resdient's while they were assisting R2. NM-A did confirm there were other staff on other units that could have assisted, but did not think of asking anyone. NM-A also confirmed R2 sat in soiled pants and a malfunctioning catheter for 2 hours and 15 minutes, before he was assisted.<br><br>Interview on 12/28/21, at 12:30 p.m. registered nurse (RN)-A stated she was the floor charge nurse working on 12/26/21, at the time of the incident. RN-A stated R2 reported his catheter leaking at 1:45 p.m. RN-A stated she had a migraine and had a medical appointment at 2:15 | F 684 | was at the time of this incident to contact the other floor staff however, administrative staff was not notified and will be in the future). Non-nursing staff such as other department managers, activity personnel and social workers will be called to aid in assisting the unit while the nursing staff are not available to answer call lights etc. This will insure the safety of all residents if an excessive number of nursing staff are occupied with one resident.<br>In the event that additional staff are needed, leadership staff including the Director of Nursing, Admission Nurse(s), Facility Administrator and other unit Nurse Manager(s) will be contacted to provide immediate assistance.<br>Resident wishes and concerns will continue to be documented, as appropriate, in all individualized care plans, care conferences.<br>Nursing leadership will meet with any resident that voices refusal to have any staff member assist with their cares and share that every attempt will be made but that resident□s safety and well-being may require any staff on duty to assist with additional personnel. Staff will document in the residents chart his/her refusal to receive cares from staff and why.<br>Coaching will occur as indicated to both resident and staff focusing on resident rights and safety as well as mutual respect.<br><br>Nurse Managers and DON will review staff exception reports weekly and audit for early out punches and staffing | |

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| F 684 | Continued From page 4<br>p.m., over her lunch period. RN-A stated she was unable to change the catheter because there was not enough time, and she was scheduled a double shift and could not change her appointment time. RN-A stated she reported this to NM-A.<br><br>Interview on 12/28/21, at 1:10 p.m. R2 stated on 12/6/21, he rang for assistance at 1:45 p.m. because his catheter was leaking. R2 stated his pants were wet form his leaking catheter. R2 indicated he was told RN-A had a medical appointment to get to and had only 15 minutes to get there. RN-A told R2 this would be passed on to NM-A. R2 stated after an hour NM-A came and told him there was not enough staff to assist him into bed and change his catheter and wet pants. When asking R2 if this bothered him, he stated he really did not have a choice, but he was not happy about it. R2 continued to state his pants were noticeably wet and he was afraid a visitor may come and see his wet pants. R2 stated he did not feel the wet pants, because he was quadriplegic. R2 indicated he was finally assisted into bed and catheter changed at 4:00 p.m. R2 indicated his cushion on his wheelchair was soaked in urine as well as his pants. R2 did not get assistance for 2 hours and 15 minutes.<br><br>Interview on 12/28/21, at 2:15 p.m. NA-A stated that she worked the evening of the incident on 12/6/21. NA-A stated she went into the R2's room about 4:15 p.m. that day to assist with putting him to bed. NA-A stated R2's pants and chair cushion were soaked with urine. NA-A indicated R2's upper back of both thighs were slightly pinkish after getting into bed. NA-A indicated R2 was very upset he had to wait for over 2 hours to have his catheter and soiled pants changed. | F 684 | numbers at those times. (6 per month on each floor).<br><br>Social Services will meet with the resident at least twice per month for the next three months to discuss timeliness of cares.<br>The urinary catheter (suprapubic catheter) policy/procedure were addressed and are available for all staff to review.<br>Quality Assurance Committee will review promptness of care for 3 months to help ensure compliance. | |

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| F 684 | Continued From page 5<br><br>A policy for catheter care was requested but not provided. | F 684 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 11, 2022

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

Re: Event ID: GCCY11

Dear Administrator:

The above facility survey was completed on December 28, 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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| | 31639 | A. BUILDING: _____ B. WING _____ | C 12/28/2021 |

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| 2 000 | Initial Comments | 2 000 | | |

*****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 12/28/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaint was found to be

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| 2 000 | Continued From page 1<br>UNSUBSTANTIATED: H5635028C (MN79590)<br>The following complaint was found to be SUBSTANTIATED: H5635029C (MN79182), however NO licensing orders were issued.<br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br>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 | | |