Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 31, 2024

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

RE: CCN: 245635
Cycle Start Date: April 17, 2024

Dear Administrator:

On May 15, 2024, 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.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 31, 2024

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

Re: Reinspection Results
Event ID: MVWW12

Dear Administrator:

On May 15, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 17, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2024

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

RE: CCN: 245635
Cycle Start Date: April 17, 2024

Dear Administrator:

On April 17, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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 July 17, 2024 (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 October 17, 2024 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: MVWW11

Dear Administrator:

The above facility was surveyed on April 16, 2024 through April 17, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@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 04/17/2024

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 4/16/24 and 4/17/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H56353224 (MN00102479) with a deficiencies cited at F656 and .F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		5/10/24

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

Electronically Signed | 05/02/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. BUILDING _____ B. WING _____	C 04/17/2024

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 656	Continued From page 1 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure	F 656	F000 Preparation and submission of this Plan of Correction does not constitute an	

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 04/17/2024

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 656	Continued From page 2 appropriate level care was provided to 1 of 3 residents (R1) reviewed for activities of daily living. Findings include: R1's admission Minimum Data set (MDS) dated 2/13/24, identified R1 had moderately impaired cognition, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's care plan, dated 2/28/24, indicated impaired physical mobility related to weakness, impaired balance, history of falls, terminal illness. R1's goals included will participate in transfers and ambulation as able. Interventions included R1 was 1 assist with transfers and transfer belt and walker, was able to walk in room and hall with 1 assist and transfer belt; revision on 3/18/24 added to include second staff to follow with wheelchair when walking. R1's progress note dated 3/22/24 at 12:43 p.m., stated new therapy recommendation from hospice for nursing to continue to transfer with front wheeled walker and gait belt for all mobility and assist second staff to follow with wheelchair. Distance as tolerated. R1's progress note dated 3/29/24 at 6:43 p.m., indicated, "[R1] had a significant change of condition within the last 24 hours. [R1] was unable to express wants and needs and unable to verbally communicate, drooling noted on left side of mouth and was staring in one direction. Unable to walk decline in mobility from baseline. [family	F 656	admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F656 Develop/Implement Comprehensive Care Plan. St. John's will ensure a comprehensive care plan is developed, and maintained to ensure appropriate level care is provided. R1 passed away on April 4, 2024. Performance Improvement Plan (PIP) was initiated on April 11, 2024, to improve our care planning process that includes temporary and comprehensive care plan implementation and timely updating as required. All residents with a change in condition, and/or if they went to the emergency room (ER), will be reviewed and evaluated to ensure an appropriate plan of care is in place by 5/7/2024. Residents, who have a change in condition, and/or if they go to the emergency room (ER), will have a Change in Condition Evaluation completed upon return to facility. DON or designee will be notified of all residents with change of condition by the nurse on duty. Policy and procedure Change of Condition	

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 04/17/2024

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 656	Continued From page 3 member] updated and [R1] was sent to emergency room [ER] for evaluation and treatment." R1's progress note dated 3/29/24 at 11:09 a.m., included resident returned from ER and was unable to communicate R1 started on Cefdinir 300 mg (antibiotic) for urinary tract infection. R1's Kardex summary printed 4/16/24 at 7:14 p.m., indicated resident was dependent with 1 assist for transfers and walker. Resident could be up as tolerated with assistance. R1's record did not include an assessment or development and implementation of care plan goals and interventions that identified R1's needs after the facility identified a decline in overall health status. During an interview on 4/17/24 at 10:25 a.m., clinical manager (CM)-A stated R1 was up and walking with one assist until revised on 3/18/24 with fall intervention to have a second staff follow with wheelchair when walking R1. CM-A stated she was familiar with R1 and identified R1 was unable to walk or verbalize needs when she had the change of condition and was sent to the hospital on 3/29/24. CM-A stated R1 had returned to the facility on 3/29/24 and still had not returned to her previous baseline after her change in condition that caused her to go to the hospital. CM-A stated she was unable to locate a comprehensive assessment completed on R1 after the change of condition and her return to the facility. R1 would not have been a one assist for transfers and or mobility after 3/29/24 and could not find changes in R1's care plan or documentation that would have accurately	F 656	was reviewed and updated on April 30, 2024, by DON and Administrator. Training and education on Change of Condition policy and evaluation was provided to licensed nursing staff on or before May 10, 2024, and any who didn't receive training and education will be removed from the schedule until completed. Auditing and monitoring of resident change of condition during daily IDT and review of 24-hour reports, will be done daily, M-F, for 4 weeks, 1x weekly for 1 month, and 2x monthly for 2 months with results being reporting to QAPI to ensure policy and process is being followed.	

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 04/17/2024

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 656	Continued From page 4 reflected the assistance R1 would have needed for mobility. CM-A stated it is an expectation that nursing staff follow the care plan of the residents but a mobility assessment had not been completed for R1 and R1's care plan was not accurate for her level of care related to mobility and activities of daily living (ADL's) on or after 3/29/24. During an interview on 4/17/24 at 1:37 p.m., director of nursing (DON) stated, R1 would not have been assist of one or been able to walk after her last hospital visit. DON stated there should have been a comprehensive assessment completed on residents who return from hospital visits to re-establish baselines with changes of condition or changes in mobility. DON recognized the need to complete assessments and the facility was already working on a plan for improvement. During an interview on 4/17/24 at 2:23 p.m., administrator stated she recognized the facility needed to work on creating better care plans for residents and had a current performance improvement plan (PIP) in place for care planning in the facility. Administrator stated the reason a PIP was in place for care plans was the management team had already recognized the need for improvement. Administrator stated she would expect nurses to complete a comprehensive assessment when a resident has a change in condition and would expect the care plan to reflect those changes. A facility policy titled Care Planning-Interdisciplinary Team, revision date 3/2022, was provided. The policy indicated the interdisciplinary team was responsible for the	F 656		

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 04/17/2024

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 656	Continued From page 5 development of resident care plans. Implementation and interpretation on the policy included: 1. Resident care plans are developed according to the timeframes and criteria established by §483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: a. the resident's attending physician. b. a registered nurse with responsibility for the resident. c. a nursing assistant with responsibility for the resident. d. a member of the food and nutrition services staff. e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.	F 656		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		5/10/24

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 04/17/2024

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 755	Continued From page 6 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer medication per physician order and failed to evaluate and address the medication errors to prevent recurrent medication errors for 1 of 3 residents (R1) reviewed for medication administration.	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records (Med Error) St. John's will ensure medication per physician order will be administered, to evaluate, and address the medication	

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 04/17/2024

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 755	Continued From page 7 Findings include: R1's admission Minimum Data set (MDS) dated, 2/13/24 identified R1 had moderate cognitive impairment, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's March and April 2024 medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per 1 milliliter (ml) (mg/ml) solution, sublingual (below tongue) SL / by mouth (PO) give 0.5 ml (1 mg) every 4 hours (q4h) for end-of-life comfort. May give PO or SL. Document indicated medication was given three times on 3/3/24 and six times on 4/4/24. R1's March medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per milliliter (ml) (mg/ml) solution, by mouth (PO) as needed (PRN) give 0.5 ml (1 mg) every 2 hours (q2h) for anxiety-for end-of-life comfort. MAR documented one dose given on 3/3/24. Facility document titled medication error report dated 4/4/24, indicated errors occurred on "multiple am and p.m." the date of error was 4/3/24. Document indicated Ativan 2 mg/ml dose given was wrong, provider had been notified and indicated, "ok to give next scheduled dose." Measures taken to prevent recurrence of similar errors was noted to "provide re-education and would investigate labeling on bottle and how the order was interpreted."	F 755	errors to prevent recurrent medication errors. R1 passed away on April 4, 2024. DON reviewed medication error report on April 16, 2024, to determine a root cause of the medication error. It was learned that the medication had changed and the agency nurse, and staff nurses administering the medication didn't follow the seven rights of medication administration, thus resulting in the error. All residents were reviewed for the same medication by DON or designee on May 5, 2024, and there are no like residents. DON will contact the pharmacy May 6, 2024, about modifying future labels on controlled liquid medications to avoid further medication errors. Controlled liquid medications will have two nurse signatures on the eMAR when dispensing the medication to give to a resident starting on or before May 10, 2024. All medication errors have been and will continue to be reviewed by DON or designee to ensure that the appropriate process is followed so no repeat errors occur. Policy and procedure "Medication Error Policy" was reviewed on April 17, 2024, with no updates needed.	

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 04/17/2024

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 755	Continued From page 8 R1's record lacked documentation of monitoring of R1 for response to overdose and/or vital signs taken before next dose was given. Further not evident the facility completed a causal analysis of what lead to the errors and develop strategies to prevent recurrent errors. During an interview on 4/17/24 at 2:56 p.m., director of nursing (DON) stated, she had been informed of the medication error to R1 on 4/4/24 when the nurse who had found the error reported R1 had been getting double the doses of Ativan. DON stated she had been informed the error had happened multiple times but had not been informed who had made the medication errors. DON stated she had not yet investigated, provided education, or put anything in place to prevent similar medication errors from reoccurring. DON indicated in the future she would make sure to investigate and provide education to prevent further medication errors. DON reviewed R1's record and identified monitoring and assessing of R1 had not occurred after the error, but she had inquired if the nurse had informed the provider of the error. The nurse had confirmed they had notified the provider and had been directed to continue with R1's current medication orders unchanged. During an interview on 4/17/24 at 2:23 p.m., administrator stated she would expect nurses to follow the medication administration policy and would refer medication errors to the DON for follow-up and or corrections. Facility policy revised 9/19, titled Medication Error Policy, indicated: · A Medication Error Report sheet will be completed on any medication/treatment error	F 755	Policy and procedure “Medication Administration Policy” was reviewed on May 5, 2024, by DON and Administrator, with the addition of two nurse signatures to verify dose and administer controlled liquid medications. Training and education of the two policies and procedures were completed with licensed nurses and trained medication aides on or before May 10, 2024, and any who didn’t receive training and education will be removed from the schedule until completed. Auditing and monitoring of each medication error will be completed by the DON or designee to make sure that the form is completed accurately, training/education with team members occurs timely, and the medication error process is followed to ensure no repeat errors occur daily, M-F, for 4 weeks, 1x weekly for 4 weeks, and 2x monthly for 2 months with results being reported to QAPI. Random auditing and monitoring of medication verification and administration of controlled liquid medications requiring two nurses will be done by the DON or designee to make sure that the right amount of medication is being given will occur daily, M-F, for 4 weeks, 1x weekly for 4 weeks, and 2x monthly for 2 months with results being reported to QAPI.	

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 04/17/2024

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 755	Continued From page 9 involving wrong dosage, wrong time, wrong resident, wrong route, wrong medication, pharmacy error, charting omission, transcription error, or any near miss. · The error report will be started and completed as much as possible by the nurse finding the error. · The error report will be signed by the person responsible for the error. The person responsible will also complete, "Measures taken to prevent the recurrence of similar error(s)." · The physician or NP will be notified, and sign medication error report. · Follow up will be on an as needed basis (labs, vital signs, neuro checks, etc.), depending on the nature of the error. · The error will be countersigned by the unit Nurse Manager and given to the Director of Nursing. · The Director of Nursing will be responsible for having it reviewed by the Medical Director and pharmacist.	F 755		

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 04/17/2024

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/16/24 and 4/17/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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 04/17/2024

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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H56353224C (MN00102479) with a licensing orders issued at (0565 and 1545). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE	2 000		

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 04/17/2024

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) COMPLETE DATE
2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate level care was provided to 1 of 3 residents (R1) reviewed for activities of daily living. Findings include: R1's admission Minimum Data set (MDS) dated 2/13/24, identified R1 had moderately impaired cognition, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's care plan, dated 2/28/24, indicated impaired physical mobility related to weakness, impaired balance, history of falls, terminal illness. R1's goals included will participate in transfers and ambulation as able. Interventions included R1	2 565	Corrected	5/10/24

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 04/17/2024

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) COMPLETE DATE
2 565	Continued From page 3 was 1 assist with transfers and transfer belt and walker, was able to walk in room and hall with 1 assist and transfer belt; revision on 3/18/24 added to include second staff to follow with wheelchair when walking. R1's progress note dated 3/22/24 at 12:43 p.m., stated new therapy recommendation from hospice for nursing to continue to transfer with front wheeled walker and gait belt for all mobility and assist second staff to follow with wheelchair. Distance as tolerated. R1's progress note dated 3/29/24 at 6:43 p.m., indicated, "[R1] had a significant change of condition within the last 24 hours. [R1] was unable to express wants and needs and unable to verbally communicate, drooling noted on left side of mouth and was staring in one direction. Unable to walk decline in mobility from baseline. [family member] updated and [R1] was sent to emergency room [ER] for evaluation and treatment." R1's progress note dated 3/29/24 at 11:09 a.m., included resident returned from ER and was unable to communicate R1 started on Cefdinir 300 mg (antibiotic) for urinary tract infection. R1's Kardex summary printed 4/16/24 at 7:14 p.m., indicated resident was dependent with 1 assist for transfers and walker. Resident could be up as tolerated with assistance. R1's record did not include an assessment or development and implementation of care plan goals and interventions that identified R1's needs after the facility identified a decline in overall health status.	2 565		

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 04/17/2024

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) COMPLETE DATE
2 565	Continued From page 4 During an interview on 4/17/24 at 10:25 a.m., clinical manager (CM)-A stated R1 was up and walking with one assist until revised on 3/18/24 with fall intervention to have a second staff follow with wheelchair when walking R1. CM-A stated she was familiar with R1 and identified R1 was unable to walk or verbalize needs when she had the change of condition and was sent to the hospital on 3/29/24. CM-A stated R1 had returned to the facility on 3/29/24 and still had not returned to her previous baseline after her change in condition that caused her to go to the hospital. CM-A stated she was unable to locate a comprehensive assessment completed on R1 after the change of condition and her return to the facility. R1 would not have been a one assist for transfers and or mobility after 3/29/24 and could not find changes in R1's care plan or documentation that would have accurately reflected the assistance R1 would have needed for mobility. CM-A stated it is an expectation that nursing staff follow the care plan of the residents but a mobility assessment had not been completed for R1 and R1's care plan was not accurate for her level of care related to mobility and activities of daily living (ADL's) on or after 3/29/24. During an interview on 4/17/24 at 1:37 p.m., director of nursing (DON) stated, R1 would not have been assist of one or been able to walk after her last hospital visit. DON stated there should have been a comprehensive assessment completed on residents who return from hospital visits to re-establish baselines with changes of condition or changes in mobility. DON recognized the need to complete assessments and the facility was already working on a plan for improvement.	2 565		

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 04/17/2024

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) COMPLETE DATE
2 565	Continued From page 5 During an interview on 4/17/24 at 2:23 p.m., administrator stated she recognized the facility needed to work on creating better care plans for residents and had a current performance improvement plan (PIP) in place for care planning in the facility. Administrator stated the reason a PIP was in place for care plans was the management team had already recognized the need for improvement. Administrator stated she would expect nurses to complete a comprehensive assessment when a resident has a change in condition and would expect the care plan to reflect those changes. A facility policy titled Care Planning-Interdisciplinary Team, revision date 3/2022, was provided. The policy indicated the interdisciplinary team was responsible for the development of resident care plans. Implementation and interpretation on the policy included: 1. Resident care plans are developed according to the timeframes and criteria established by §483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: a. the resident's attending physician. b. a registered nurse with responsibility for the resident. c. a nursing assistant with responsibility for the resident. d. a member of the food and nutrition services staff. e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident.	2 565		

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 04/17/2024

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) COMPLETE DATE
2 565	Continued From page 6 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 565		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or	21545		5/10/24

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 04/17/2024

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) COMPLETE DATE
21545	Continued From page 7 (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to administer medication per physician order and failed to evaluate and address the medication errors to prevent recurrent medication errors for 1 of 3 residents	21545	Corrected	

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 04/17/2024

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) COMPLETE DATE
21545	Continued From page 8 (R1) reviewed for medication administration. Findings include: R1's admission Minimum Data set (MDS) dated, 2/13/24 identified R1 had moderate cognitive impairment, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's March and April 2024 medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per 1 milliliter (ml) (mg/ml) solution, sublingual (below tongue) SL / by mouth (PO) give 0.5 ml (1 mg) every 4 hours (q4h) for end-of-life comfort. May give PO or SL. Document indicated medication was given three times on 3/3/24 and six times on 4/4/24. R1's March medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per milliliter (ml) (mg/ml) solution, by mouth (PO) as needed (PRN) give 0.5 ml (1 mg) every 2 hours (q2h) for anxiety-for end-of-life comfort. MAR documented one dose given on 3/3/24. Facility document titled medication error report dated 4/4/24, indicated errors occurred on "multiple am and p.m." the date of error was 4/3/24. Document indicated Ativan 2 mg/ml dose given was wrong, provider had been notified and indicated, "ok to give next scheduled dose." Measures taken to prevent recurrence of similar errors was noted to "provide re-education and would investigate labeling on bottle and how the order was interpreted."	21545		

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 04/17/2024

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) COMPLETE DATE
21545	Continued From page 9 R1's record lacked documentation of monitoring of R1 for response to overdose and/or vital signs taken before next dose was given. Further not evident the facility completed a causal analysis of what lead to the errors and develop strategies to prevent recurrent errors. During an interview on 4/17/24 at 2:56 p.m., director of nursing (DON) stated, she had been informed of the medication error to R1 on 4/4/24 when the nurse who had found the error reported R1 had been getting double the doses of Ativan. DON stated she had been informed the error had happened multiple times but had not been informed who had made the medication errors. DON stated she had not yet investigated, provided education, or put anything in place to prevent similar medication errors from reoccurring. DON indicated in the future she would make sure to investigate and provide education to prevent further medication errors. DON reviewed R1's record and identified monitoring and assessing of R1 had not occurred after the error, but she had inquired if the nurse had informed the provider of the error. The nurse had confirmed they had notified the provider and had been directed to continue with R1's current medication orders unchanged. During an interview on 4/17/24 at 2:23 p.m., administrator stated she would expect nurses to follow the medication administration policy and would refer medication errors to the DON for follow-up and or corrections. Facility policy revised 9/19, titled Medication Error Policy, indicated: · A Medication Error Report sheet will be completed on any medication/treatment error	21545		

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 04/17/2024

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) COMPLETE DATE
21545	Continued From page 10 involving wrong dosage, wrong time, wrong resident, wrong route, wrong medication, pharmacy error, charting omission, transcription error, or any near miss. · The error report will be started and completed as much as possible by the nurse finding the error. · The error report will be signed by the person responsible for the error. The person responsible will also complete, "Measures taken to prevent the recurrence of similar error(s)." · The physician or NP will be notified, and sign medication error report. · Follow up will be on an as needed basis (labs, vital signs, neuro checks, etc.), depending on the nature of the error. · The error will be countersigned by the unit Nurse Manager and given to the Director of Nursing. · The Director of Nursing will be responsible for having it reviewed by the Medical Director and pharmacist. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		