Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2023

Administrator
St. John's on Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: September 7, 2023

Dear Administrator:

On October 5, 2023, we notified you a remedy was imposed. On October 20, 2023 the Minnesota Department(s) 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 October 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 7, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 21, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 7, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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October 23, 2023

Administrator
St. John's on Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: Reinspection Results
Event ID: FBCX12

Dear Administrator:

On October 20, 2023, 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 September 7, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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October 5, 2023

Administrator
St. John's on Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: September 7, 2023

Dear Administrator:

On September 21, 2023, we informed you that we may impose enforcement remedies.

On September 20, 2023, the Minnesota Department(s) of Health completed a survey, and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

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(ies) 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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 7, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 7, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 7, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

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 $11,995, 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.

If you have not achieved substantial compliance by December 7, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St. John's on Fountain Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 7, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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" 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 - Health Regulation Division 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 March 7, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 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

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 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 09/20/2023

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 9/20/23, 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 complaints were reviewed. H56355666C (MN00097014) and H56355473C (MN00096810). Deficient practice was identified related to incidental finding at F554 and F880. 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan	F 554	F000 Preparation and submission of this Plan of	10/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/06/2023

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 554	Continued From page 1 was followed for self-administration of medications for 1 of 1 residents (R3) whose medications were left at R3's bedside. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/26/23, identified R3 had diagnoses of progressive neurological conditions and did not have cognitive impairment. R3's care plan dated 8/3/23, included R3 was not responsible for self-administration of medications as it was physically impossible but was able to self-administer a nebulizer treatment after a nurse prepares. During an observation on 9/20/2023, at 11:01 a.m. R3's call light was on, R3 was in the bathroom, and R3's family member (FM)-A sat in a chair next to the bed. On top of the bedside table there was a paper souffle cup that contained eight medications. No staff were present. FM-A stated R3 was put on the toilet by the nurse about five minutes ago. During an observation on 9/20/23, at 11:05 a.m. nursing assistant (NA)-A entered R3's room and assisted him off the toilet and into his bed. NA-A took R3's medications in the cup and handed them to R3 assisting him by holding his beverage cup while he attempted to swallow his medications. NA-A was unable to identify what medications were in the cup. NA-A stated the nurse had left the medications in the room for R3 to take so, she was helping R3 to take them. During an interview on 9/20/23, at 11:14 a.m. licensed practical nurse (LPN)-A indicated earlier	F 554	Correction does not constitute an 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. F554 Resident Self-Admin Meds-Clinically Appropriate St. John's on Fountain Lake have, and always will, ensure the right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Staff LPN-A was re-educated by DON on Medication Administration Procedures and self-administration of medication on 9/20/2023. Those policies were reviewed on 9/20/2023 with updates made to self-administration of medication policy. Training and education on Medication Administration Procedure and self-administration of medications policies will occur with TMA's and Nurses starting on 10/6/2023 and to be completed by 10/13/2023. DON or designee will audit/monitor staff who are completing direct cares with residents to ensure proper glove use and hand hygiene, daily, Monday-Friday, starting on 10/13/2023 for 4 weeks, 3x	

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F 554	Continued From page 2 this morning she set R3's medications on his bedside table and administered R3's nebulizer treatment. When she returned to remove the nebulizer she assisted R3 to the bathroom, however did not realize R3 had not taken his medications. LPN-A was to aware NA-A had provided the medication to R3. LPN-A stated an awareness if R3 had the ability to self-administer medications in pill form until she reviewed R3's record. She then R3 was not able to self-administer his medications and she should not have left the medications in his room. During an interview on 9/20/23, at 3:14 p.m. director of nursing (DON) stated if a resident did not have an order to self-administer medications the nurse should stay with the resident until the medications are taken and the medications should not be left in the room. Facility Policy, Self Administration of Medication Policy, dated 9/2029, indicated the facilities policy is to provide the opportunity to qualified resident to self administer medications. To self administer residents must have a written nurse practitioner or physician order allowing self medication.	F 554	weekly for 4 weeks, weekly for three months. Results will be reported to QAPI.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		10/13/23

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F 880	Continued From page 3	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 4 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was maintained during cares for 1 of 1 resident (R3) observed during personal cares. Findings include: During on observation on 9/20/23, at 11:01 a.m. nursing assistant (NA)-A entered R3's room to answer his call light and noted R3 to be sitting in the bathroom on the toilet. . NA-A put on gloves, assisted R3 to stand, and obtained wipes to clean R3's bottom as he had a bowel movement. With gloves on NA-A wiped R3's bottom removing the stool. Using the same gloves NA-A had used during peri-cares, NA-A assisted R3 to pull up his underwear and pants. She then grabbed his walker and held his catheter bag while assisting him back to his bed. NA-A then laid the catheter bag on R3's bed and pulled the bedside table out of the way. NA-A then assisted R3 to sit on his	F 880	F880 Infection Prevention/Control St. John's on Fountain Lake have, and always will, ensure that there is an established and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Staff NA-A was re-educated by DON on 9/20/2023 about proper infection control practices regarding glove usage and hand hygiene. Hand Hygiene and Infection Control policy was reviewed by DON and Infection preventionist with no changes noted on 9/20/2023.	

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F 880	Continued From page 5	F 880		

bed and lifted his legs up into the bed. NA-A then removed her gloves but held them in her hand and without performing hand hygiene NA-A gave R3 his medications and a drink from his beverage cup that were sitting on the bedside table. NA-A then took the medication cup and placed it in her dirty gloves and threw the gloves away. NA-A then touched the bedside table placing it close to R3 and placed R3's call light within reach. .

During an interview on 9/20/23, at 11:15 a.m. NA-A confirmed she had not performed appropriate hand hygiene after providing R3 personal cares. NA-A further indicated even after she had removed her gloves her hands were considered dirty and she had touched R3's legs, medicine cup, and drink. NA-A stated she had not cleaned or sanitized her hands until after she had left R3's room.

During an interview on 9/20/23, at 3:14 p.m. director on nursing (DON) stated, staff should be removing gloves and washing or sanitizing hands after all peri-cares.

Facility policy, Hand Hygiene, dated 2/1/22, identified hand hygiene general indication for hand washing/Alcohol-Based Sanitizer; immediately before touching a resident, before performing a aseptic task, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the residents immediate environment, after contact with blood or body fluids or contaminated surfaces, immediately after glove removal.

Training and education on hand hygiene and infection control policy was initiated with all care staff on 10/6/2023 to be completed by 10/13/2023.

DON or designee will audit/monitor staff who are completing direct cares with residents to ensure proper glove use and hand hygiene, daily, Monday-Friday, starting on 10/13/2023 for 4 weeks, 3x weekly for 4 weeks, weekly for three months. Results will be reported to QAPI.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 5, 2023

Administrator
St. John's on Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: FBCX11

Dear Administrator:

The above facility was surveyed on September 20, 2023, 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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 09/20/2023

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 9/20/23, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1	2 000		

The following complaints were reviewed. H56355666C (MN00097014), H56355473C (MN00096810)

Deficient practice was identified related to incidental finding at 1390 and 1565.

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

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2 000	Continued From page 2 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.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was maintained during cares for 1 of 1 resident (R3) observed during personal cares. Findings include: During on observation on 9/20/23, at 11:01 a.m. nursing assistant (NA)-A entered R3's room to answer his call light and noted R3 to be sitting in the bathroom on the toilet. . NA-A put on gloves, assisted R3 to stand, and obtained wipes to clean R3's bottom as he had a bowel movement. With gloves on NA-A wiped R3's bottom removing the stool. Using the same gloves NA-A had used during peri-cares, NA-A assisted R3 to pull up his underwear and pants. She then grabbed his walker and held his catheter bag while assisting him back to his bed. NA-A then laid the catheter bag on R3's bed and pulled the bedside table out of the way. NA-A then assisted R3 to sit on his	21385	F000 Preparation and submission of this Plan of Correction does not constitute an 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. F880 Infection Prevention/Control St. John’s on Fountain Lake have, and always will, ensure that there is an established and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	10/13/23

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21385	Continued From page 3 bed and lifted his legs up into the bed. NA-A then removed her gloves but held them in her hand and without performing hand hygiene NA-A gave R3 his medications and a drink from his beverage cup that were sitting on the bedside table. NA-A then took the medication cup and placed it in her dirty gloves and threw the gloves away. NA-A then touched the bedside table placing it close to R3 and placed R3's call light within reach. . During an interview on 9/20/23, at 11:15 a.m. NA-A confirmed she had not performed appropriate hand hygiene after providing R3 personal cares. NA-A further indicated even after she had removed her gloves her hands were considered dirty and she had touched R3's legs, medicine cup, and drink. NA-A stated she had not cleaned or sanitized her hands until after she had left R3's room. During an interview on 9/20/23, at 3:14 p.m. director on nursing (DON) stated, staff should be removing gloves and washing or sanitizing hands after all peri-cares. Facility policy, Hand Hygiene, dated 2/1/22, identified hand hygiene general indication for hand washing/Alcohol-Based Sanitizer; immediately before touching a resident, before performing a aseptic task, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the residents immediate environment, after contact with blood or body fluids or contaminated surfaces, immediately after glove removal. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures	21385	Staff NA-A was re-educated by DON on 9/20/2023 about proper infection control practices regarding glove usage and hand hygiene. Hand Hygiene and Infection Control policy was reviewed by DON and Infection preventionist with no changes noted on 9/20/2023. Training and education on hand hygiene and infection control policy was initiated with all care staff on 10/6/2023 to be completed by 10/13/2023. DON or designee will audit/monitor staff who are completing direct cares with residents to ensure proper glove use and hand hygiene, daily, Monday-Friday, starting on 10/13/2023 for 4 weeks, 3x weekly for 4 weeks, weekly for three months. Results will be reported to QAPI.	

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21385	Continued From page 4 and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		10/13/23

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21390	Continued From page 5 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was maintained during cares for 1 of 1 resident (R3) observed during personal cares. Findings include: During on observation on 9/20/23, at 11:01 a.m. nursing assistant (NA)-A entered R3's room to answer his call light and noted R3 to be sitting in the bathroom on the toilet. . NA-A put on gloves, assisted R3 to stand, and obtained wipes to clean R3's bottom as he had a bowel movement. With gloves on NA-A wiped R3's bottom removing the stool. Using the same gloves NA-A had used during peri-cares, NA-A assisted R3 to pull up his underwear and pants. She then grabbed his walker and held his catheter bag while assisting him back to his bed. NA-A then laid the catheter bag on R3's bed and pulled the bedside table out of the way. NA-A then assisted R3 to sit on his bed and lifted his legs up into the bed. NA-A then removed her gloves but held them in her hand and without performing hand hygiene NA-A gave R3 his medications and a drink from his beverage cup that were sitting on the bedside table. NA-A then took the medication cup and placed it in her dirty gloves and threw the gloves away. NA-A then touched the bedside table placing it close to R3 and placed R3's call light within reach. During an interview on 9/20/23, at 11:15 a.m. NA-A confirmed she had not performed appropriate hand hygiene after providing R3 personal cares. NA-A further indicated even after	21390	F880 Infection Prevention/Control St. John's on Fountain Lake have, and always will, ensure that there is an established and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Staff NA-A was re-educated by DON on 9/20/2023 about proper infection control practices regarding glove usage and hand hygiene. Hand Hygiene and Infection Control policy was reviewed by DON and Infection preventionist with no changes noted on 9/20/2023. Training and education on hand hygiene and infection control policy was initiated with all care staff on 10/6/2023 to be completed by 10/13/2023. DON or designee will audit/monitor staff who are completing direct cares with residents to ensure proper glove use and hand hygiene, daily, Monday-Friday, starting on 10/13/2023 for 4 weeks, 3x weekly for 4 weeks, weekly for three months. Results will be reported to QAPI.	

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21390	Continued From page 6 she had removed her gloves her hands were considered dirty and she had touched R3's legs, medicine cup, and drink. NA-A stated she had not cleaned or sanitized her hands until after she had left R3's room. During an interview on 9/20/23, at 3:14 p.m. director on nursing (DON) stated, staff should be removing gloves and washing or sanitizing hands after all peri-cares. Facility policy, Hand Hygiene, dated 2/1/22, identified hand hygiene general indication for hand washing/Alcohol-Based Sanitizer; immediately before touching a resident, before performing a aseptic task, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the residents immediate environment, after contact with blood or body fluids or contaminated surfaces, immediately after glove removal. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		