



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

Electronically Delivered  
October 16, 2024

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

RE: CCN: 245635  
Cycle Start Date: September 24, 2024

Dear Administrator:

On October 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.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



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October 16, 2024

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

Re: Reinspection Results  
Event ID: JUTJ12

Dear Administrator:

On October 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 September 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



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October 2, 2024

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

RE: CCN: 245635  
Cycle Start Date: September 24, 2024

Dear Administrator:

On September 24, 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:

St Johns On Fountain Lake

October 2, 2024

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- 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, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
Rochester District Office  
3425 40th Avenue NW, Suite 115  
Rochester, MN 55901  
Email: [Lisa.Krebs@state.mn.us](mailto: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 December 24, 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 March 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

St Johns On Fountain Lake

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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/ltr\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/ltr_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](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



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

Re: State Nursing Home Licensing Orders  
Event ID: JUTJ11

Dear Administrator:

The above facility was surveyed on September 20, 2024 through September 24, 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](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.

St Johns On Fountain Lake

October 2, 2024

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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, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
Rochester District Office  
3425 40th Avenue NW, Suite 115  
Rochester, MN 55901  
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.



Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245635</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNS ON FOUNTAIN LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1771 EAGLE VIEW CIRCLE</b> <b>ALBERT LEA, MN 56007</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 9/20/24 and 9/24/24, 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.</p> <p>The following complaint was reviewed: H56358602C (MN00106787), and H56358020C (MN00106420) with deficiencies cited at F880.</p> <p>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.</p> <p>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.</p>	F 000		
F 880 SS=D	<p><b>Infection Prevention &amp; Control</b> CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p><b>§483.80 Infection Control</b> 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.</p> <p><b>§483.80(a) Infection prevention and control program.</b> The facility must establish an infection prevention and control program (IPCP) that must include, at</p>	F 880		10/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>10/11/2024</b>
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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 880	<p>Continued From page 1</p> <p>a minimum, the following elements:</p> <p>§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 §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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 contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 880		

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F 880	<p>Continued From page 2</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 record review the facility failed to utilize enhanced barrier precautions (EBP) for 2 of 5 residents (R1, R2) observed with personal cares.</p> <p>Findings include:</p> <p>Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device. High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing.</p>	F 880	<p>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.</p> <p>F880 Infection Prevention &amp; Control Enhanced Barrier Precautions (EBP) Resident 1 EBP was put in place on 9/24/2024. Resident 2 EBP was put in place on 9/24/2024. Residents # 4, 5, and 6, had EBP put in place on 9/24/2024.</p>	

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F 880	<p>Continued From page 3</p> <p>R1's face sheet dated 9/24/24, identified diagnoses of bullous pemphigoid (rare skin condition that causes large, fluid-filled blisters).</p> <p>R1's significant change Minimum Data Set (MDS) dated 7/18/24, identified severe cognitive impairment. R1 required assist (A) of one person for dressing, bathing, and hygiene.</p> <p>R1's wound care visit dated 9/17/24, identified R1 had left first and second toe ulceration in the setting of bullous pemphigoid. R1 had wound debridement (removal of dead or infected tissue from wound to promote healing) performed.</p> <p>R1's care plan dated revised 9/20/24, identified wound management to left foot. A second area focused on enhanced barrier precautions revised on 9/17/24, identified staff to follow standard precautions, including proper handwashing techniques, to minimize microorganism transmission enhanced barrier precautions will be used in addition to standard precautions during high contact care activities.</p> <p>During an observation and interview on 9/24/24 at 11:36 a.m., clinical manager (CM)-A applied gait belt to R1, transferred R1 from recliner to wheelchair, and wheelchair to toilet without EBP. CM-A assisted with pulling brief down. CM-A washed hands and put gloves on. CM-A stated direction for using EBP would be located on the computer. CM-A verified she should be wearing EBP as she was performing high contact cares. CM-A put gown on, assisted R1 with toilet hygiene. CM-A removed gown and gloves and assisted R1 from wheelchair to recliner.</p>	F 880	<p>All residents were reviewed for EBP, on or before 10/09/20204, and it was determined that 2 additional residents needed EBP put in place. This was done immediately.</p> <p>EBP Policy and Procedure was reviewed on 9/27/2024 by Director of Nursing (DON) and full QAPI committee with no changes necessary.</p> <p>All new admissions will be reviewed for EBP by infection preventionist and/or designee to ensure appropriate EBP is put in place.</p> <p>Training and education on EBP will be done with C.N.A's, and licensed nurses, during daily auditing Monday-Friday for 1 month, 1x weekly for 1 month, and 1x monthly for 1 month to ensure compliance.</p> <p>An audit will be done daily Monday-Friday for 1 month on residents with EBP in place, 1x weekly for 1 month, and 1x monthly for 1 month by DON, or designee, to ensure compliance with policy and procedure with results being reported to QAPI.</p>	

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F 880	<p>Continued From page 4</p> <p>During an observation on 9/20/24 at 12:12 p.m., nursing assistant (NA)-A observed putting gait belt around R1, transferred R1 from recliner to wheelchair, wheelchair to toilet, and toilet to wheelchair after performing toilet hygiene. NA-A did not use EBP for high contact care.</p> <p>During an interview on 9/20/24 at 2:37 p.m., NA-C stated EBP instructions for residents could be found on the inside of the residents' cabinet door and in the care plan.</p> <p>R2's face sheet dated 9/24/24, identified malignant neoplasm of bladder (bladder cancer), hydronephrosis (urine unable to drain from a kidney properly causing the kidney to swell), absence of other parts of the urinary tract.</p> <p>R2's significant change MDS dated 6/20/24, identified severe cognitive impairment. R2 required two staff with transfers, assist of one staff with cares.</p> <p>R2's care plan revised 6/4/24, identified R2 had a urostomy. A second area focused on enhanced barrier precautions revised on 9/17/24, identified staff to follow standard precautions, including proper handwashing techniques, to minimize microorganism transmission enhanced barrier precautions will be used in addition to standard precautions during high contact care activities.</p> <p>During an observation on 9/20/24 at 1:12 p.m., NA-A and NA-B transferred R2 from wheelchair to recliner. NA-A and NA-B did not wear EBP for high contact care.</p> <p>During an interview on 9/24/24 at 1:45 p.m., infection preventionist (IP)-A stated education on</p>	F 880		

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NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNS ON FOUNTAIN LAKE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1771 EAGLE VIEW CIRCLE</b> <b>ALBERT LEA, MN 56007</b>		
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F 880	<p>Continued From page 5</p> <p>EBP was provided at every meeting to nursing staff along with audits of staff. IP-A stated management staff are working on processes to ensure residents on EBP have the processes in place.</p> <p>During an interview on 9/24/24 at 2:10 p.m., Director of Nursing (DON) stated it was her expectation that EBP would be followed and that it was in easy to locate places.</p> <p>The facility EBP policy and procedure dated 4/1/24, identified EBP was used to reduce the transmission of MDRO.</p> <p>3.Nursing staff will implement EBPs for residents who have a wound or indwelling medical device.</p> <p>a.Wounds: include chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers,</p> <p>c. Indwelling medical devices include central line catheters, peripherally inserted central line catheters (PICC), feeding tubes, and tracheostomies,</p> <p>d. Indwelling medical devices do not include peripheral IV lines, healed ostomies, dialysis shunts that do not have access to the outside of the body, or port-a-caths.</p> <p>4. High-contact resident care activities include dressing, bathing, showering, transferring, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care.</p> <p>PROCEDURE:</p> <p>1. Enhanced Barrier Precautions (EBP) requires staff to use gloves and gowns during close contact resident care for residents who have a history of or colonization with a CDC-targeted MDRO.</p> <p>4. If the resident is colonized with or has a history of infection of a MDRO, nursing staff will</p>	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245635</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNS ON FOUNTAIN LAKE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1771 EAGLE VIEW CIRCLE</b> <b>ALBERT LEA, MN 56007</b>		
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F 880	Continued From page 6 implement EBP. 5. If the resident has a wound or indwelling medical device, nursing staff will implement EBP. 6. If nursing staff becomes aware of the resident's history of or colonization with a MDRO, nursing staff will implement EBP. 7. Post appropriate signate for type of precautions, signage is located inside bottom cubby of resident's room. 8. Gowns, gloves, and hand sanitizer will be readily accessible for use outside the resident's room. 9. The IP/Designee will provide staff, residents and/or resident representatives with education regarding the purpose of EBP. 10. When EBP is initiated for a resident, this will be communicated to staff in the Special Instructions section on Point Click Care and on EMAR. 14. EBPs are in the resident's Kardex	F 880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>31639</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/24/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST JOHNS ON FOUNTAIN LAKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007</b>
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2 000	<p><b>Initial Comments</b></p> <p><b>*****ATTENTION*****</b></p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 9/20/24 and 9/24/24, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE  	(X6) DATE  <b>10/11/24</b>
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed: H56358602C (MN00106787) and H56358020C (MN00106420) with licensing orders issued at 1390.</p> <p>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.</p> <p>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 &lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; 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</p>	2 000		
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2 000	Continued From page 2  state form.  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.	2 000		
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 current standards of practice in infection control.	21390		10/10/24

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21390	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to utilize enhanced barrier precautions (EBP) for 2 of 5 residents (R1, R2) observed with personal cares.</p> <p>Findings include:</p> <p>Per the Centers for Disease Control (CDC) dated 6/28/24: EBP are indicated during high contact care activities for residents with infection or colonization with a CDC targeted multi-drug resistant organisms (MDRO) (when contact precautions do not apply) or for any resident who has a chronic wound and/or indwelling medical device.</p> <p>High-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care: generally, for residents with a chronic wound(s), not skin breaks or tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing.</p> <p>R1's face sheet dated 9/24/24, identified diagnoses of bullous pemphigoid (rare skin condition that causes large, fluid-filled blisters).</p> <p>R1's significant change Minimum Data Set (MDS) dated 7/18/24, identified severe cognitive impairment. R1 required assist (A) of one person for dressing, bathing, and hygiene.</p> <p>R1's wound care visit dated 9/17/24, identified R1 had left first and second toe ulceration in the setting of bullous pemphigoid. R1 had wound</p>	21390	<p>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.</p> <p>F880 Infection Prevention &amp; Control Enhanced Barrier Precautions (EBP)</p> <p>Resident 1 EBP was put in place on 9/24/2024.</p> <p>Resident 2 EBP was put in place on 9/24/2024.</p> <p>Residents # 4, 5, and 6, had EBP put in place on 9/24/2024.</p> <p>All residents were reviewed for EBP, on or before 10/09/2024, and it was determined that 2 additional residents needed EBP put in place. This was done immediately.</p> <p>EBP Policy and Procedure was reviewed on 9/27/2024 by Director of Nursing (DON) and full QAPI committee with no changes necessary.</p> <p>All new admissions will be reviewed for</p>	

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21390	<p>Continued From page 4</p> <p>debridement (removal of dead or infected tissue from wound to promote healing) performed.</p> <p>R1's care plan dated revised 9/20/24, identified wound management to left foot. A second area focused on enhanced barrier precautions revised on 9/17/24, identified staff to follow standard precautions, including proper handwashing techniques, to minimize microorganism transmission enhanced barrier precautions will be used in addition to standard precautions during high contact care activities.</p> <p>During an observation and interview on 9/24/24 at 11:36 a.m., clinical manager (CM)-A applied gait belt to R1, transferred R1 from recliner to wheelchair, and wheelchair to toilet without EBP. CM-A assisted with pulling brief down. CM-A washed hands and put gloves on. CM-A stated direction for using EBP would be located on the computer. CM-A verified she should be wearing EBP as she was performing high contact cares. CM-A put gown on, assisted R1 with toilet hygiene. CM-A removed gown and gloves and assisted R1 from wheelchair to recliner.</p> <p>During an observation on 9/20/24 at 12:12 p.m., nursing assistant (NA)-A observed putting gait belt around R1, transferred R1 from recliner to wheelchair, wheelchair to toilet, and toilet to wheelchair after performing toilet hygiene. NA-A did not use EBP for high contact care.</p> <p>During an interview on 9/20/24 at 2:37 p.m., NA-C stated EBP instructions for residents could be found on the inside of the residents' cabinet door and in the care plan.</p> <p>R2's face sheet dated 9/24/24, identified malignant neoplasm of bladder (bladder cancer),</p>	21390	<p>EBP by infection preventionist and/or designee to ensure appropriate EBP is put in place.</p> <p>Training and education on EBP will be done with C.N.A's, and licensed nurses, during daily auditing Monday-Friday for 1 month, 1x weekly for 1 month, and 1x monthly for 1 month to ensure compliance.</p> <p>An audit will be done daily Monday-Friday for 1 month on residents with EBP in place, 1x weekly for 1 month, and 1x monthly for 1 month by DON, or designee, to ensure compliance with policy and procedure with results being reported to QAPI.</p>	

Minnesota Department of Health

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21390	<p>Continued From page 5</p> <p>hydronephrosis (urine unable to drain from a kidney properly causing the kidney to swell), absence of other parts of the urinary tract.</p> <p>R2's significant change MDS dated 6/20/24, identified severe cognitive impairment. R2 required two staff with transfers, assist of one staff with cares.</p> <p>R2's care plan revised 6/4/24, identified R2 had a urostomy. A second area focused on enhanced barrier precautions revised on 9/17/24, identified staff to follow standard precautions, including proper handwashing techniques, to minimize microorganism transmission enhanced barrier precautions will be used in addition to standard precautions during high contact care activities.</p> <p>During an observation on 9/20/24 at 1:12 p.m., NA-A and NA-B transferred R2 from wheelchair to recliner. NA-A and NA-B did not wear EBP for high contact care.</p> <p>During an interview on 9/24/24 at 1:45 p.m., infection preventionist (IP)-A stated education on EBP was provided at every meeting to nursing staff along with audits of staff. IP-A stated management staff are working on processes to ensure residents on EBP have the processes in place.</p> <p>During an interview on 9/24/24 at 2:10 p.m., Director of Nursing (DON) stated it was her expectation that EBP would be followed and that it was in easy to locate places.</p> <p>The facility EBP policy and procedure dated 4/1/24, identified EBP was used to reduce the transmission of MDRO.</p> <p>3.Nursing staff will implement EBPs for residents</p>	21390		

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21390	<p>Continued From page 6</p> <p>who have a wound or indwelling medical device.</p> <p>a. Wounds: include chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers,</p> <p>c. Indwelling medical devices include central line catheters, peripherally inserted central line catheters (PICC), feeding tubes, and tracheostomies,</p> <p>d. Indwelling medical devices do not include peripheral IV lines, healed ostomies, dialysis shunts that do not have access to the outside of the body, or port-a-caths.</p> <p>4. High-contact resident care activities include dressing, bathing, showering, transferring, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care.</p> <p><b>PROCEDURE:</b></p> <p>1. Enhanced Barrier Precautions (EBP) requires staff to use gloves and gowns during close contact resident care for residents who have a history of or colonization with a CDC-targeted MDRO.</p> <p>4. If the resident is colonized with or has a history of infection of a MDRO, nursing staff will implement EBP.</p> <p>5. If the resident has a wound or indwelling medical device, nursing staff will implement EBP.</p> <p>6. If nursing staff becomes aware of the resident's history of or colonization with a MDRO, nursing staff will implement EBP.</p> <p>7. Post appropriate signate for type of precautions, signage is located inside bottom cubby of resident's room.</p> <p>8. Gowns, gloves, and hand sanitizer will be readily accessible for use outside the resident's room.</p> <p>9. The IP/Designee will provide staff, residents and/or resident representatives with education regarding the purpose of EBP.</p> <p>10. When EBP is initiated for a resident, this will</p>	21390		
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21390	<p>Continued From page 7</p> <p>be communicated to staff in the Special Instructions section on Point Click Care and on EMAR.</p> <p>14. EBPs are in the resident's Kardex</p> <p><b>SUGGESTED METHO OF CORRECTION:</b> The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. In additon, the DON or designee should review and ensure compliance with g-tube feeding/medication administration with audits to ensure policies are being followed to ensure on-going competence. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> 21 (twenty-one) DAYS</p>	21390		