DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 24, 2022

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: CCN: 245407
Cycle Start Date: March 23, 2022

Dear Administrator:

On May 13, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, 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

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Electronically delivered

May 24, 2022

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Re: Reinspection Results
Event ID: RDXG12

Dear Administrator:

On May 13, 2022 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 March 23, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any 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

DEPARTMENT OF HEALTH

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Electronically delivered
March 31, 2022

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

RE: CCN: 245407
Cycle Start Date: March 23, 2022

Dear Administrator:

On March 23, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 23, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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 3/23/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED, however a related deficiency was cited at F888. H5407037C (MN81891) H5407038C (MN81217) H5407039C (MN80758) The following complaint was found to be SUBSTANTIATED: H5407036C (MN80613), however NO deficiencies were cited due to actions implemented by the facility prior to survey. 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 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully	F 888		4/29/22

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

Electronically Signed | 04/07/2022

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

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F 888	Continued From page 1 vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 888	Continued From page 2 staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not	F 888		

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F 888	Continued From page 3 the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;	F 888		

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F 888	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 115 staff, laundry aide (LA)-A, were fully vaccinated for Covid-19 vaccinations, or had completed documentation of a medical or religious exemption or conducting bi-weekly Covid-19 testing. This resulted in a 99.1% vaccination rate. This practice created the potential for the spread of the Covid-19 virus to other staff and residents who resided in the facility. Findings include: During review of Section I of document titled Covid-19 Staff Vaccination Status for Providers, from the Centers for Medicare and Medicaid Services, which was completed at the request of the State Agency (SA), it was noted that one staff member was identified as "not vaccinated without exemption/delay." Facility policy titled Exemption Policy and Procedure for Covid-19 Vaccination, dated 11/15/21, indicated all employees were required to receive the Covid-19 vaccination unless a reasonable accommodation was approved as an identified approved exemption. Employees who were approved for exemption would be required to do Covid-19 rapid testing twice a week prior to punching into work. Furthermore, employees who were not approved for an exemption, and/or had not received their first dose of a Covid-19 vaccine, or failed to comply with an exemption request would be removed from the schedule. During an interview on 3/23/22, at 2:10 p.m., the director of nursing (DON) was asked to identify	F 888	Laundry Aide was removed from the schedule until they received COVID-19 vaccination and has since voluntarily resigned. No residents were found to be affected by the deficient practice. Reviewed and updated the COVID-19 vaccination form for new employees. Onboarding of new employees will include review of testing requirements. Reviewed and updated Exemption Policy and Procedure for COVID-19. Inservice scheduled for all staff on 4/19/22 and 4/20/22 to review and reeducate on Exemption Policy and testing requirements. Education of all Department Managers on 4/11/22 on CMS Vaccine Mandate, Exemption process and testing requirements. Audits of required documentation for vaccine mandate will be completed of new employees x3 months. COVID-19 testing audits will be completed weekly x 1month to ensure all unvaccinated staff are meeting the facility's exemption policy requirements. Results will be reported to monthly QAPI Committee for further recommendation and need for ongoing audits. HR director, Director of Nursing, or designee will monitor overall compliance.	

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F 888	Continued From page 5	F 888		

the staff member who was "not vaccinated without exemption/delay." The DON stated it was LA-A who started employment on 3/2/22, as a full-time laundry aide. The DON stated LA-A had initially tried to get an exemption, but it was denied. This was verified by review of a document titled Covid-19 Vaccination Form in which LA-A indicated she wished to refuse to receive the Covid-19 vaccination. This documented was signed and dated by LA-A on 3/1/22. After this denial, LA-A then agreed to receive the Covid-19 vaccine. On 3/7/22, a Covid-19 Vaccine Consent form giving consent to receive the vaccine was signed by LA-A, but she had not yet received a dose.

The DON admitted that LA-A "got missed" for both Covid-19 vaccination and bi-weekly Covid-19 testing and had been working in the facility since 3/2/22. In addition, the DON stated it was her responsibility to ensure employees received the Covid-19 vaccination. The DON stated LA-A's Covid-19 vaccination consent form was with other papers on her desk and was overlooked. The DON stated her understanding of the facility policy was employees needed to be vaccinated or have an approved exemption, or would not be able to work. In addition, the DON stated the policy also required unvaccinated employees to test for Covid-19 twice a week. The DON admitted the policy wasn't followed in this case; that LA-A had not been vaccinated for Covid-19, had not received an approved exemption, nor had undergone bi-weekly Covid-19 testing.

Review of timecards for LA-A which were provided by the DON, indicated LA-A worked a total of 71.5 hours between 3/2/22, through

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F 888	Continued From page 6 3/23/22, and that LA-A's role required going into resident rooms. During the same interview, the DON stated there had been no problem getting the Covid-19 vaccination from the local pharmacy. Facility policy titled Exemption Policy and Procedure for Covid-19 Vaccination, dated 11/15/21, indicated all employees were required to receive the Covid-19 vaccination unless a reasonable accommodation was approved as an identified approved exemption. Employees who were approved for exemption would be required to do Covid-19 rapid testing twice a week prior to punching into work. Furthermore, employees who were not approved for an exemption, and/or had not received their first dose of a Covid-19 vaccine, or failed to comply with an exemption request would be removed from the schedule. By January 4, 2021 (sic), if not in compliance of policy, it would be considered a voluntary resignation.	F 888		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2022

Administrator
St John Lutheran Home
201 South County Road 5
Springfield, MN 56087

Re: State Nursing Home Licensing Orders
Event ID: RDXG11

Dear Administrator:

The above facility was surveyed on March 23, 2022 through March 23, 2022 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:

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

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	C 03/23/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/23/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00045	A. BUILDING: _____ B. WING _____	C 03/23/2022

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ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5407037C (MN81891), H5407038C (MN81217), H5407039C (MN80758; however, a related licensing order was issued at tag identification 1390. The following complaint was found to be SUBSTANTIATED, however NO licensing orders were issued: H5407036C (MN80613) 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	2 000		

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2 000	Continued From page 2 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 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	21390		4/29/22

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21390	Continued From page 3 disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 115 staff, laundry aide (LA)-A, were fully vaccinated for Covid-19 vaccinations, or had completed documentation of a medical or religious exemption or conducting bi-weekly Covid-19 testing. This resulted in a 99.1% vaccination rate. This practice created the potential for the spread of the Covid-19 virus to other staff and residents who resided in the facility. Findings include: During review of Section I of document titled Covid-19 Staff Vaccination Status for Providers, from the Centers for Medicare and Medicaid Services, which was completed at the request of the State Agency (SA), it was noted that one staff member was identified as "not vaccinated without exemption/delay." Facility policy titled Exemption Policy and Procedure for Covid-19 Vaccination, dated 11/15/21, indicated all employees were required to receive the Covid-19 vaccination unless a reasonable accommodation was approved as an identified approved exemption. Employees who were approved for exemption would be required to do Covid-19 rapid testing twice a week prior to punching into work. Furthermore, employees who were not approved for an exemption, and/or had not received their first dose of a Covid-19	21390	Corrected	

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21390	Continued From page 4 vaccine, or failed to comply with an exemption request would be removed from the schedule. During an interview on 3/23/22, at 2:10 p.m., the director of nursing (DON) was asked to identify the staff member who was "not vaccinated without exemption/delay." The DON stated it was LA-A who started employment on 3/2/22, as a full-time laundry aide. The DON stated LA-A had initially tried to get an exemption, but it was denied. This was verified by review of a document titled Covid-19 Vaccination Form in which LA-A indicated she wished to refuse to receive the Covid-19 vaccination. This documented was signed and dated by LA-A on 3/1/22. After this denial, LA-A then agreed to receive the Covid-19 vaccine. On 3/7/22, a Covid-19 Vaccine Consent form giving consent to receive the vaccine was signed by LA-A, but she had not yet received a dose. The DON admitted that LA-A "got missed" for both Covid-19 vaccination and bi-weekly Covid-19 testing and had been working in the facility since 3/2/22. In addition, the DON stated it was her responsibility to ensure employees received the Covid-19 vaccination. The DON stated LA-A's Covid-19 vaccination consent form was with other papers on her desk and was overlooked. The DON stated her understanding of the facility policy was employees needed to be vaccinated or have an approved exemption, or would not be able to work. In addition, the DON stated the policy also required unvaccinated employees to test for Covid-19 twice a week. The DON admitted the policy wasn't followed in this case; that LA-A had not been vaccinated for Covid-19, had not received an approved exemption, nor had undergone bi-weekly Covid-19 testing.	21390		

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21390	Continued From page 5 Review of timecards for LA-A which were provided by the DON, indicated LA-A worked a total of 71.5 hours between 3/2/22, through 3/23/22, and that LA-A's role required going into resident rooms. During the same interview, the DON stated there had been no problem getting the Covid-19 vaccination from the local pharmacy. Facility policy titled Exemption Policy and Procedure for Covid-19 Vaccination, dated 11/15/21, indicated all employees were required to receive the Covid-19 vaccination unless a reasonable accommodation was approved as an identified approved exemption. Employees who were approved for exemption would be required to do Covid-19 rapid testing twice a week prior to punching into work. Furthermore, employees who were not approved for an exemption, and/or had not received their first dose of a Covid-19 vaccine, or failed to comply with an exemption request would be removed from the schedule. By January 4, 2021 (sic), if not in compliance of policy, it would be considered a voluntary resignation. SUGGESTED METHOD OF CORRECTION: The facility director of nursing (DON) or designee could review and revise policies and procedures in relation to the facility's infection control program related to Covid-19 vaccinations. The DON or designee could provide education to all facility staff. The DON or designee could do weekly/monthly audits for compliance. The DON or designee could report findings of the audits to the Quality Assurance and Performance Improvement (QAPI) committee for recommendations to ensure ongoing compliance.	21390		

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21390	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21390		