DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2024

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

RE: CCN: 245407
Cycle Start Date: April 17, 2024

Dear Administrator:

On April 17, 2024, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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 July 17, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 17, 2024 (six months), after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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 04/17/2024

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
E 000	Initial Comments On 4/15/24 through 4/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/15/24 through 4/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 with NO deficiencies cited: H54072710C (MN99774) and H54072709C (MN 96997). 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 substantial compliance with the regulations has been attained.	F 000		
F 623	Notice Requirements Before Transfer/Discharge	F 623		6/7/24

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

Electronically Signed | 05/10/2024

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

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F 623 SS=B	Continued From page 1 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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F 623	Continued From page 2 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 3 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure written transfer notices were provided to the resident or resident representative following a facility-initiated transfer to the hospital for 2 of 2 residents (R25, R28) reviewed for hospitalization. This had the potential to affect all 49 residents residing in the facility. Findings include: R25's Record of Admission printed 4/17/24, included diagnoses of urinary tract infection, hydronephrosis (excess urine accumulation in kidney causing swelling the kidney) and hypertensive chronic kidney disease (high blood pressure causing kidney damage) R25's readmission Minimum data set (MDS) dated 4/15/24, indicated R25 had mild cognitive	F 623	R25 and R28 were provided reason for transfer and discharge in writing on 5/10/2024. Copy sent to resident representative. All residents who have transferred or discharged have potential to be affected. Transfer Notice Policy Developed. Transfer notice form implemented and updated transfer out checklist. Education on transfer notice to all licensed staff, Health Information and Social Services by 6/7/2024. Transfers out will include a copy of transfer discharge notice. Administrator or designee will conduct audits on transfers out weekly x 2months and will report to QAPI committee for further review and recommendations.	

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F 623	Continued From page 4	F 623		

impairment but understands and is understood.

During interview on 4/15/24 at 12:50 p.m., R25 indicated she was recently in the hospital and did not remember being given any paper work prior to her transfer there. R25 indicated she had a urinary tract infection prior to going to the hospital.

A progress note dated 4/2/24 by registered nurse (RN)-B indicated R25 was sent to a local hospital via ambulance at 2:20 p.m. and returned to the facility on 4/5/24 at 3:15 p.m. R25's medical record lacked evidence written notice of the transfer had been provided to R25 or representative.

R28's Record of Admission printed 4/17/24, included diagnoses of dementia, diabetes mellitus, atherosclerotic heart disease of native coronary artery (plaque build-up in artery) and arrythmia (abnormal heart rhythm).

R28's quarterly MDS dated 4/7/24, indicated severe cognitive impairment but understands and is understood.

During interview 4/15/24 at 2:28 p.m., R28's family member (FM)-C stated stated R28 was sent to the local hospital last fall where they found he had a blood clot in his lung. FM-C indicated he never received a written notice of transfer and R28's medical record lacked evidence a written notice of the transfer was provided to R28 or FM-C.

A progress note dated 9/16/23 at 8:45 a.m. by RN-B indicated R28 was transferred via ambulance to local hospital. On 9/22/23 at 11:48

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F 623	Continued From page 5 a.m., licensed practical nurse (LPN)-B's progress note indicated R28 was readmitted to the facility at 10:05 a.m.. R28's medical record lacked evidence written notice of the transfer had been provided to R28 or representative. During interview 4/16/24 at 2:18 p.m., LPN-A indicated a Transfer Form is filled out with the resident information present on it for the hospital but nothing is given in writing to the residents or family. During interview 4/16/24 at 2:25 p.m., the director of nursing (DON) confirmed they are not completing a transfer notice, nor giving a copy to the resident or family member. Requested a policy and procedure on transfer agreements and none was received. The admission packet dated 9/19/23, included a section on Transfer and Discharge that included in case of an emergency transfer, the facility will notify the resident or responsible person prior to the transfer, if possible. When time does not permit a prior notification, the facility will contact the responsible person as soon thereafter as possible.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		6/7/24

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F 625	Continued From page 6 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of an emergency transfer for 2 of 2 residents (R25, R28) who were transferred to an acute care facility on an emergency basis. Findings include: R25's Record of Admission printed 4/17/24, included diagnoses of urinary tract infection, hydronephrosis (excess urine accumulation in kidney causing swelling the kidney) and hypertensive chronic kidney disease (high blood pressure causing kidney damage)	F 625	R25 and R28 were notified of the facilities bed hold policy and copy sent to resident representative on 5/10/24. All residents who have been hospitalized or on therapeutic leave have potential to be affected. Audits will be completed on all current residents for bed hold notification. Copy of bed holds will be sent to family/resident representative. Reviewed and revised Bed Hold Policy. Updated policy communicated to family/resident representative and updated copy placed in admission packets. Education on Bed Hold Policy and notification to resident and family/resident representative will be completed with	

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F 625	Continued From page 7 R25's readmission Minimum data set (MDS) dated 4/15/24, indicated R25 had mild cognitive impairment but understands and is understood. A progress note, dated 4/2/24, by registered nurse (RN)-B indicated R25 was sent to a local hospital via ambulance at 2:20 p.m. and returned to the facility on 4/5/24 at 3:15 p.m. R25's medical record lacked evidence a Bed Hold policy was shared with R25 or her representative at the time of transfer. During interview on 4/15/24 at 12:50 p.m., R25 indicated she was recently in the hospital and did not remember being given any paper work or being asked about a bed hold prior to her transfer. R25 indicated she had a urinary tract infection prior to going to the hospital. A Bed Hold Notice for R25 was signed by RN-B, dated 4/2/24, stating I wish to reserve my room. A separate line signature line was present if not the resident that included title (if not the resident), which was blank. R28's Record of Admission printed 4/17/24, included diagnoses of dementia, diabetes mellitus, arteriosclerotic heart disease of native coronary artery (plaque build-up in artery) and arrhythmia (abnormal heart rhythm). R28's quarterly MDS dated 4/7/24, indicated severe cognitive impairment but understands and is understood. A progress note dated 9/16/23 at 8:45 a.m. by RN-B indicated R28 was transferred via ambulance to local hospital. On 9/22/23 at 11:48 a.m., licensed practical nurse (LPN)-B's progress	F 625	Licensed Staff and Health Information by 6/7/2024. Health Information will be responsible to ensure copy of bed hold notice sent to family/resident representative. Director of Nursing or designee will complete weekly audits x 2 months and will report to QAPI committee for further review and recommendations.	

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F 625	Continued From page 8	F 625		

note indicated R28 was readmitted to the facility at 10:05 a.m.. R28's medical record lacked evidence a Bed Hold policy was shared with R28 or his representative at the time of transfer.

During interview 4/15/24 at 2:28 p.m., R28's family member (FM)-C stated stated R28 was sent to the local hospital last fall where they found he had a blood clot in his lung. FM-C indicated he was not asked about a bed hold nor was he given a copy of the policy.

A Bed Hold Notice for R28 was signed by RN-B, dated 9/16/23, stating I wish to reserve my room. Title (if not the resident) was left blank.

During interview 4/16/24 at 2:18 p.m., LPN-A indicated a Bed Hold Notice is completed prior to discharge and send to the hospital. LPN-A indicated families or the resident rarely sign the Bed Hold Notice form and a copy isn't shared with them unless they request a copy.

During interview 4/16/24 at 2:25 p.m., the director of nursing (DON) indicated the facility used to send a copy of the Bed Hold Notice to the family if they weren't present at time of transfer, but does not believe that is currently happening due to turn over in staff. The DON indicated the staff should get verbal permission from the resident or family and document as verbal permission on the Bed Hold Notice form and not sign the form themselves.

The facility Bed Hold policy dated 1/2019, included when the resident is absent for any reason, including hospitalization, the resident may continue to occupy the room if the resident pays the daily room rate authorized by law. For

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F 625	Continued From page 9 Medical Assistance residents the bed-hold limit for each hospitalization is 18 days and if leave exceeds the resident will be discharged from the facility. If Private Pay, any resident may hold his or her bed by paying the rate currently in effect. Residents of Medicare can not go on overnight visits without jeopardizing Medicare benefits.	F 625		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow manufacturer's instructions for cleaning and sanitizing 1 of 1 ice machines used for resident consumption. This had the potential to affect all 49 residents who resided in the facility.	F 812	Ice and water dispensing machine cleaning has been added to the Tel's maintenance app. This will set up a biannual reminder of when the cleaning process of the machine needs to be completed per the owner's manual of the machine which states cleaning/sanitizing	6/7/24

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	245407	A. BUILDING _____ B. WING _____	C 04/17/2024

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

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F 812	Continued From page 10 Findings include: During an observation on 4/16/24 at 10:39 a.m., noted a Manitowoc brand, counter-top style ice machine in the first floor resident ice machine. During an interview on 4/15/24 at 11:35 a.m., dietary supervisor (DS)-B stated dietary staff wiped down the outside of the ice machine located in the first-floor dining room but did not clean the inside. During an interview on 4/17/24 at 11:17 a.m., dietary aide (DA)-A stated she cleaned the ice machine using hot water and a long narrow brush to clean a long, narrow PVC pipe laying horizontal alongside the bottom of the ice machine. DA-A stated dietary staff did not clean the inside of the ice machine; didn't empty out the ice or do anything else to it. DA-A verified the ice machine was used for resident consumption. Reviewed Manitowoc ice machine Use & Care Manual, received from plant operations director (POD)-A. The manual identified three separate cleaning procedures: 1) Preventative Maintenance Cleaning Procedure - recommended monthly; 2) Cleaning/Sanitizing, recommended a minimum of once every six months; 3) Heavily Scaled Cleaning Procedure if the ice machine had certain symptoms. During an interview on 4/17/24 at 11:40 a.m., POD-A stated plant operations staff did not clean the ice machine; dietary staff took care of that. POD-A was informed dietary staff was not cleaning the ice machine according to manufacture instructions in order to prevent the growth of bacteria. POD-A acknowledged no one	F 812	procedure must be completed a minimum once every 6 months. The Plant Operation's Director will oversee this and make sure it is completed on time. This will be reported to the QAPI committee and will be reviewed for further recommendations.	

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F 812	Continued From page 11 in the facility was cleaning the ice machine according to manufacture instructions. Manufacturer's instructions for Manitowoc RNS12 & RNS20 Model Nugget Ice Machines Installation, Use & Care Manual, dated 10/13. Cleaning and Sanitizing - the facility is responsible for maintaining the ice machine in accordance with the instructions in this manual. Clean and sanitize the ice machine every six months for efficient operation. The Manitowoc Ice Machine has three separate cleaning procedures: 1. Preventative Maintenance Cleaning Procedure. Perform this procedure as required for water conditions. Recommended monthly. Allows cleaning the ice machine without removing all the ice from the bin. Removes mineral deposits from areas or surfaces that are in direct contact with water during the freeze cycle (reservoir, evaporator, auger, drain lines). 2. Cleaning/Sanitizing Procedure. This procedure must be performed a minimum of once every six months. All ice must be removed from the bin. The ice machine and bin must be disassembled, cleaned, and sanitized. The ice machine produces ice with the cleaner and sanitizer solutions. All ice produced during the cleaning and sanitizing procedures must be discarded. 3. Heavily Scaled Cleaning Procedure. Perform this procedure if have some or all these symptoms: Grinding, popping or squealing noises from the evaporator. Grinding noise from gearbox. Ice machine stops on Safety Shutdown. Your water has a high concentration of minerals. The ice machine has not been on a regular maintenance schedule. Run a cleaning procedure as described above after this procedure is complete. NOTE: A Sanitizing Procedure must be	F 812		

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F 812	Continued From page 12 performed after all cleaning procedures have been completed.	F 812		
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 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;	F 880		6/7/24

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F 880	Continued From page 13 (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 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 and interview, the facility failed to ensure basic infection control measures were followed when 1 of 1 resident (R41's) urinary drainage bag was observed resting on the floor. Findings include:	F 880	R41 urinary drainage bag was placed in a protective bag and off floor immediately. All residents with catheters are at risk for this deficient practice. Identified residents with catheters and ensured urinary drainage bags had proper protective bag and was off floor.	

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F 880	Continued From page 14 R41's diagnosis list printed on 4/17/24, included history of pulmonary emboli (when arteries are blocked by a blood clot). R41's significant change Minimum Data Set (MDS) dated 2/26/24, indicated severe cognitive impairment and dependency upon staff for most activities of daily living. R41's physician orders dated 9/8/23, indicated indwelling urinary catheter. R41's care plan dated 9/15/23, indicated Foley (describes the type of catheter) catheter management per MD (medical doctor) orders and facility protocol. During an observation on 4/15/24 at 1:39 p.m., observed R41's urinary drainage bag hooked to the side pocket of his cloth recliner, resulting in the bottom of the bag, including the urinary drainage valve, to rest on the floor. During an observation on 4/16/24 at 8:18 a.m., R41 was in his recliner eating breakfast. Observed R41's urinary drainage bag hooked to the side pocket of his recliner, resulting in the bottom of the bag, including the urinary drainage valve, to rest on the floor. During an interview and observation on 4/16/24 at 9:05 p.m., together with licensed practical nurse (LPN)-A looked at the location of R41's urinary drainage bag. LPN-A stated the bag was supposed to be kept off the floor to prevent the possibility of a urinary tract infection (UTI). LPN-A asked nursing assistant (NA)-A to obtain a pouch in which to put R41's bag.	F 880	Reviewed and revised Catheter Care policy. Education provided to all nursing staff on Catheter Care by 6/7/2024. Director of Nursing or designee will complete random audits of catheter bag compliance weekly x 2 months and will report to QAPI committee for review and further recommendations.	

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F 880	Continued From page 15 During an interview and observation on 4/16/24 at 9:07 a.m., together with NA-A, looked at the location of R41's urinary drainage bag. NA-A stated that was not where she would hang R41's bag and acknowledged the bag should not rest on the floor due to the possibility of bacteria entering the bag. NA-A placed the urinary drainage bag in a cloth pouch and set the pouch in the side pocket of the recliner. During an interview on 4/16/24 at 12:30 p.m., registered nurse (RN)-A who was also the infection preventionist, stated staff were trained to keep a urinary drainage bag off the floor and acknowledged the potential for bacterial growth if the bag was on the floor. During an interview on 4/17/24 at 11:24 a.m., the director of nursing (DON) was informed of observations of R41's urinary drainage bag resting on the floor. The DON stated she would expect staff to position the bag so that it would not rest on the floor or to place it in a cloth pouch or a plastic basin. The facility Catheter Care - Urinary policy dated 5/24/22, indicated the purpose of the procedure was to prevent catheter-associated urinary tract infection. The policy did not address how staff should position the urinary drainage bag when the resident was in bed, in a chair, or a wheelchair.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/16/2024. At the time of this survey, St John Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 05/10/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This 2-story with partial basement facility is fully fire sprinkler protected, and was constructed as follows: *The original building was built in 1961 and determined to be of Type II(000) construction; *The 1972 Addition was determined to be of Type II(000) construction; *The 1987 Addition was determined to be of Type II (222) construction; *The 1991 Addition was determined to be of Type	K 000		

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K 000	Continued From page 2 II (222) construction, with a portion of the Addition being of Type V(111) construction; *The 2000 Addition was determined to be of Type III (211) construction. The facility has a capacity of 65 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code,	K 353	The sprinkler heads in the freezer are being checked weekly for ice and frost build up. This will be monitored weekly	6/7/24

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K 353	Continued From page 3 sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2024 at 10:30AM, it was revealed by observation that the fire sprinkler heads in the freezer were completely encased with ice and frost, making these heads unoperable. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	until the defrost termination relay is replaced by Schwikert's Tecta America. Schwickert's believe this is the cause for the ice build up on the celing and the freezer sprinkler pipe. Plant Operations Director will oversee this and will audit to verify the part is working.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct 3rd shift fire drill during the 1st quarter per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4 through 19.7.1.7. This deficient finding could have a isolated impact on the residents within the facility.	K 712	Fire drill documentation will now be a two-copy form so there will be a second sheet of the completed fire drill. Plant operations will monitor and keep these files available in the Plant Director's office and Maintenance shop. The Plant Operations Director will oversee this and make sure it is completed on time. Fire	6/7/24

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K 712	Continued From page 4 Findings include: On 04/16/2024 at 10AM, it was revealed by a review of available documentation that the facility failed to conduct 3rd shift fire drill during the 1st quarter . An interview with the Maintenance Director verified this deficient finding at the time of disovery.	K 712	Drills will be added to our monthly safety meeting agenda and will be reviewed.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		6/7/24

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K 918	Continued From page 5 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the emergency generator on a weekly from 3/13/2024 to 04/19/2024 per NFPA 99 (2012 edition), Health Care Facilities Code, sections 16.4.4, 6.5.4, 6.6.4, (NFPA 99), NFPA 110, NFPA 111 and 700.10 (NFPA 70). This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/16/2024 at 10:15AM, it was revealed by observation and staff interview that there is no documentation to review to show that weekly inspections on the emergency generator occurred from 03/13/2024 to 04/19/2024.	K 918	Weekly gnerator check sheets have been added to the Tel's maintenance app. This will set up a weekly reminder to the maintenance department to complete the task. The Plant Operations Director will oversee this and make sure it is completed on time.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		6/7/24

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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
K 923	Continued From page 6 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 04/16/2024 at 10:15AM, it was revealed by observation that two oxygen cylinders in the	K 923	All staff with access to the oxygen room provided education on proper oxygen storage and oxygen safety. Oxygen safety policy reviewed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2024**

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K 923	Continued From page 7 Oxygen Cylinder Storage Room were stored without being on storage rack or chained to the wall. An interview with the Maitenance Director verified this deficient finding at the time of discovery.	K 923		