STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245372	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Lukes Lutheran Care Center	1219 South Ramsey Blue Earth, MN 56013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review the facility failed ensure a residents residing in the memory care unit were allowed clothing in a manner to promote dignity when residents were dressed in a hospital gown while participating in activities for 3 of 4 residents (R4, R9, R49) reviewed for dignity. Findings Include: R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R4 had moderately impaired cognition, required moderate assistance with dressing upper body and maximal assistance dressing her lower body and diagnoses of non-Alzheimer's dementia and depression. R4's care plan dated 3/7/25, indicated alterations and potential for further alterations in ADL (activities of daily living) abilities evidenced by history of falls, history TIA, diagnosis of unspecified dementia with behavioral disturbance, and visual impairment. Interventions included extensive assistance of 1-2 to dress, participates by lifting arms and helps to pull shirt on and dependent on staff to put pants on as well as socks and shoes. R9's quarterly MDS assessment dated [DATE], indicated R9 had severe cognitive impairment, required maximal assistance with dressing upper body and dependent on staff assistance dressing her lower body and diagnoses of weakness, non-Alzheimer's dementia, anxiety, and depression R9's care plan dated 2/7/25, indicated alterations in dressing, grooming, and bathing as evidenced by need for assistance and interventions included requires extensive to total assistance of one with daily dressing. R49's quarterly MDS assessment dated [DATE], indicated R9 had severe cognitive impairment, required maximal assistance with dressing upper body and dependent on staff assistance dressing her lower body and diagnoses of weakness, non-Alzheimer's dementia. R49's care dated 2/28/25, indicated alteration in ADL's evidenced by need for assistance with all aspects due to weakness and confusion extensive assist of 1-2 to dress, participates by lifting arms and legs with cues, one staff to keep calm or busy or on task while one staff to complete the task as resident is very busy with her hands and grabs at items, tries to sit or stand when not appropriate, etc, will sometimes also help to pull items part way on. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 6:00 p.m., R4, R9, R40, R49 were observed in the moonlight wing (locked memory care unit) activity area seated in wheelchairs wearing hospitals gowns, and nine other residents were present. The residents were positioned in a circle and participated in an activity while wearing a hospital style gown, where a ball was kicked around the circle from resident to resident. On 4/7/25 at 6:05 p.m., nursing assistant (NA)-A stated R4, R9, and R49 were assisted with evening cares after their evening meal. NA-A stated R4, R9, and R49 wore a hospital gown to bed and staff assisted with changing some of the residents into a hospital gown after the evening meal and then the residents were assisted back to the commons area. NA-A stated it was common facility practice that the residents participated in activities in their hospital gown. On 4/7/25 at 6:08 p.m., NA-E stated after the resident's evening meal staff routinely assisted some of the residents with evening cares and assisted resident's into a hospital gown they wore to bed. NA-E stated staff assisting some of the residents with evening cares after the evening meal was more convenient for staff to get the residents into their gown after the evening meal when toileting the residents. NA-E stated a reasonable person would not participate in activities wearing a hospital gown. On 4/7/25 at 6:14 p.m., NA-D and stated staff routinely assisted residents with evening cares after the the evening meal and into the hospital gown they wore to bed, and then the resident's would return to the commons area for activities. NA-D stated assisting some of the residents with bedtime cares after the evening meal helped staff get the residents to bed on time. NA-D stated she had never thought of residents wearing a gown during activities as a dignity concern as they wear the gown to bed. On 4/7/25 at 6:21 p.m., staff were observed and assisted the nine residents with an activity where a large ball was placed in the center of the circle of residents, and the residents kicked the ball around the circle. After that activity residents were assisted the dining room table area for a new activity. R4, R9, R49 were observed in hospital gowns and seated in their wheelchairs at the dining room table. On 4/7/25 at 6:22 p.m., R9 was seated in a wheelchair in a hospital gown with a blanket over her lap at the dining room table and staff were observed assisting other residents to the dining room for an activity. R9 stated she would rather wear normal clothes then wear the gown she was wearing while doing an activity. On 4/7/25 at 6:23 p.m., R4 and R49 were not able to verbalize if they had concerns wearing a hospital gown while they participated in activities. On 4/7/25 at 6:26 p.m., NA-B stated staff assisted residents to their rooms after the evening meal for toileting and stated some of the residents were provided evening cares at that time that included putting a hospital gown on that they wore to bed. NA-B stated residents who wore a gown to activities were expected to have a blanket on their lap and a sweater cover their top of the body . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 9:50 a.m., NA-C stated it was common for residents to wear hospital gowns to evening activities and stated a blanket was expected on the resident's lap and sweater if a hospital gown was worn while residents participated in activities. NA-C stated R4, R9, R49 were cognitively impaired and not able to verbalize if they would want to wear a gown during activities. NA-C stated a reasonable person would not wear a hospital gown during an activity. On 4/8/25 at 10:16 a.m., during telephone interview R49's family member (FM)-A stated R49 was a modest person and would not want wear a hospital gown while participating in activities. FM-A stated R49 was no longer able to make decisions or speak for herself. On 4/8/25 at 11:53 a.m., the director of nursing (DON) stated stated residents were not expected to wear a gown while participating in activities in a common area unless a blanket was placed over the resident's lap, or a sweater covering the upper body. The DON confirmed R4, R9, R49 were not able to verbalize if they had concerns with wearing a gown during activities and families had not been asked the resident preference. The DON stated resident's in other areas of the facility do not participate in activities wearing hospital gowns. Facility Resident Right to Receive Respect and Dignity policy dated 10/20/23, indicated It is the goal to provide dignity and respect to all residents in full recognition of their individuality. This includes but is not limited to the following: The right to retain personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority -SMHA) for 2 of 2 resident (R10 and R14) with new onset of mental illness since admission. Findings include: R10's 7/05/23, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II (PASARR) to be completed. R10's 12/26/24, quarterly Minimum Data Set (MDS) assessment identified R10 was admitted [DATE]. R10 had a diagnoses of non-traumatic brain dysfunction, dementia, anxiety, depression, and a psychotic disorder other than schizophrenia. R10 was severely cognitively impaired and took antipsychotic, antidepressant, and antianxiety medication on a routine basis. R10 was dependent on staff for cares and activities of daily living (ADLs). Section D-Mood, on the MDS, identified R10 had little interest or pleasure in doing things, felt down, depressed or hopeless, had trouble falling, staying asleep or slept too much, felt bad about herself, had let herself or family down, had trouble concentrating on things, moved or spoke slowly that other people would noticed, was fidgety, restless, stated that life isn't worth living, wished for death or attempt to harm self, was short tempered, and easily annoyed never to 1 day. R10 had felt tired, had little energy, had poor appetite or was overeating 12 to 14 days, during the 14-day assessment period. R10's undated, current diagnosis list identified R10 received a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 9/07/23. R10's undated, current care plan identified R10 was at risk for alteration in mood and behaviors related to late Alzheimer's dementia with psychotic disturbances, anxiety, unspecified psychosis not due to substance or known physiological condition and depression disorder. R10 had a history of verbal outburst, not wanting to be alone at times, physical aggression towards staff, and confusion. R10 was at risk for psychotropic medication side effects such as constipation, nausea, fatigue, poor appetite, dizziness and nervousness, and adverse drug reactions. R10 was at risk for psychosocial well-being related to traumatic life events of R10's past and present. Interventions was for staff to provide referrals to mental health professional, support groups and other appropriate resources as needed. R10's medical record lacked any indication that the county (SMHA) had been notified since the new onset of R10's mental illness. R14's 11/10/16, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II (PASARR) to be completed. R14's 5/24/18, Confidential Protected Health Information Enclosed faxed sheet identified a notice of voluntary transfer of R14 to the local hospital for changes in behavior. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's 12/06/24, Risk and Benefit Assessment and Psych Summary identified R14 had a history of paranoia and delusions, was anxious, had thoughts of people talking about him and listening to his conversations, and had made bizarre verbal statements. R14's 1/10/25, quarterly Minimum Data Set (MDS) was admitted [DATE]. R14 had a diagnosis of depression and schizophrenia. R14 was cognitively intact and took antipsychotics and antidepressants on a routine basis. R14 required substantial/maximal assistance for cares and was dependent on staff for transfers. Section D-Mood, on the MDS, identified R14 had little interest or pleasure in doing things and had felt down, depressed, or hopeless never to 1 day, during the 14-day assessment period. R14's undated, current diagnosis list identified R14 received a new diagnosis of paranoid delusional disorder on 7/05/18, social phobia on 6/11/20 and schizoaffective disorder, depressive type on 6/11/20. R14's undated, current care plan identified R14 was at risk for alteration in mood related to depressive disorder, and delusional disorder. R14 had a history of suicidal thoughts or hurting oneself, auditory hallucinations and delusions. R14 was at risk for antidepressant antipsychotic medication use and had target behaviors of paranoia, anger and impatience. R14's medical record lacked any indication that the county (SMHA) had been notified since the new onset of R14's mental illness. Interview on 4/08/25 at 2:25 p.m., with licensed social worker identified the facility relied on the hospital to initiate the PASARR prior to admission. She identified she was not aware R10 and R14 new mental illness diagnoses. She identified the mental health authority was not contacted for referral. Interview on 4/09/25 at 11:06 a.m., with director of nursing had no knowledge of when to determine a Level II screening would be required. She stated her expectations would be for the facility to identify a process to review residents with a new mental illness for a Level II screening. Review of September 2024 Preadmission Screening Process For Entering A SNF policy identified Level I PASARR would be completed on residents before admission to the facility. In addition, the facility would notify the state mental health authority or state intellectual disability authority after a significant change in the mental or physical condition or a resident who had a mental illness or intellectual disability.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to identify, comprehensively assess and implement interventions for a 9.7 percent weight loss in one month for of 1 of 1 resident (R19) reviewed for nutrition. Findings include: R19's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R19 had moderately impaired cognition, no behaviors or rejection of care, a weight of 213 pounds, had a loss of 5% or more in the last month or loss of 10% or more in the last months and was not on physician prescribed weight loss regimen, required set up assistance with eating, dependent on staff for toileting, dressing, and required moderate assistance with personal hygiene, and diagnoses included hemiplegia or hemiparesis (weakness or partial paralysis on one side of the body), depression and weakness. R19's nutritional status Care Area Assessment (CAA) worksheet dated 5/16/24, indicated potential for alterations in nutritional status secondary to BMI (body mass index), at risk for weight gain or loss, dehydration, and/or skin breakdown, see nutritional documents, diagnosis list, physician orders, will proceed to nutritional care plan to address needs. R19's care plan dated 2/17/25, indicated potential for alteration in nutrition related to cerebral infarction (stroke) and interventions included diet: regular with average sized portions, regular liquid consistencies and regular texture foods, provide meals upon her request, independent with feeding herself, provide/set up as needed, encourage to eat, monitor food and fluid intake at meals, acceptance and tolerance to diet. Document titled MDS Listing Checklist dated 2/12/25, indicated current weight 213, weight one month ago 236, weight loss 9.75% in month, weight 6 months ago 234, significant weight change yes, regular diet, appetite varies, supplements in diet order. Progress note dated 11/7/24, dietary manager (DM)-A indicated R19 receiving a general diet with regular food textures and regular liquid consistencies, consuming approximately 75-100% of food served at 3 meals daily, this is good to excellent intake, able to feed self after tray is set up, most recent weight: 242 pounds, which is up 4 pounds from last month, no issues chewing or swallowing, skin is intact, continue to monitor weight, intake, and acceptance and tolerance to diet. R19's progress note dated 3/25/25 registered dietician (RD)-A indicated R19 had a significant weight change, as defined by regulatory standards, in the last 30-day reporting period, weight history is as follows: most recent weight: 245 pounds, BMI=46.3 (extreme obesity), based on 61 inches, 30-day weight: 213 pounds, up 32 pounds; 15% 165-day admission weight: 238 pounds, up 7 pounds, 3%; receives a general diet with regular food textures and regular liquid consistencies, consumes approximately 75% of food served at 3 meals daily, 90% of the time, this is good to excellent but is in excess of calorie needs, no issues chewing or swallowing, skin is intact, encourage healthful food selection, continue to monitor weight, intake, and acceptance and tolerance to diet. R19's vitals report printed 4/9/25, indicated the following weights: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1/24 242 pounds 11/8/24 236 pounds 12/1/24 243 pounds 1/1/25 236 pounds 2/1/25 213 pounds 3/1/25 245 pounds; 5.0 percent change in weight in 30 days 4/1/25 245 pounds On 4/9/25 at 7:34 a.m., during a telephone interview the registered dietician confirmed R19 had a significant weight loss form 1/1/25 to 2/1/25, that was not addressed. RD-A stated interventions were expected implemented with R19's significant weight loss of 9.7% in one month. RD-A stated she was responsible to address significant weight loss and confirmed R19's weight loss was not addressed as expected. On 4/9/25 at 8:25 a.m., RN-B stated the nursing assistants were responsible to weigh and document R19's weight monthly. RN-B stated on 2/1/25, and she reweighed R19's due to the significant weight loss from the previous month and ensure the documentation and weight was not an error. RN-B stated she has no documentation R19's weight on 2/1/25, was an error. RN-B stated a list of resident's weights were given to RN-C, known as the resident care coordinator, to address weights. RN-B stated she would have expected R19's signification weight loss addressed and investigated. On 4/8/25-4/9/25, RN-C was unavailable for an interview. On 4/9/25 at 8:33 a.m., R19 was seated in a wheelchair in the dining room and stated she ate her meal with no concerns. R19 was observed to have ate 100 percent of her breakfast meal. R19 stated she had no weight loss or no weight gain recently and further stated staff checked her weight weekly. On 4/9/25 at 8:35 a.m., dietary manager (DM)-A stated dietary assessed resident weights quarterly and DM-A was observed to find a document titled MDS Listing Checklist dated 2/12/25, and stated the document confirmed R19's significant weight loss. DM-A stated RD-A will address the significant weight loss and gains and was responsible for interventions. On 4/9/25 at 9:57 a.m., registered nurse (RN)-A, also known as the MDS nurse, confirmed R19 had a significant weight loss and confirmed R19's weight loss form 1/1/25 to 2/2/25, was not identified and was not aware of inventions put in place for the R19's weight loss. RN-A further explained R19's weight was maybe an error; however, the weight loss was not investigated to determine if R19 had actual weight loss or an error. On 4/9/25 at 9: 59 a.m., the director of nursing (DON) stated she would expect R19's weight loss on 2/1/25, identified and interventions put in place to follow the facilities policy and procedure. The DON further indicated there was not documentation R19's weight loss was identified or addressed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Unplanned Weight Loss Management policy dated 1/18, indicated committed to providing a plan of care that supports each resident's optimal level of wellness. This includes acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrates that this is not possible. Procedure: All residents are weighed upon admission, readmission and at least monthly on an ongoing basis. Residents at risk of weight loss are scheduled for more frequent weights as deemed appropriate by the health care team. Resident weights are taken and entered into their electronic health record. The RN Resident Care Coordinator is responsible for reviewing weights and determining the need for re-weights and notification of dietician and physician. Triggers for weight loss concern include 5% weight loss in one month and 10% weight loss in six months. The Registered Dietician reviews residents' nutritional status with the MDS schedule and upon notification of concerns by Dietary Manager and/or Nursing Department staff. After review, the Registered Dietician will make recommendations that will be communicated to the resident's physician.