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	06/23/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to assess a significant weight gain, obtain a reweigh, and notify the physician 1 of 1 resident (F54) reviewed for weight gain. Findings include: R54's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, required partial/moderate assistance with personal hygiene and sit to stand, a weight of 213 pounds, no Gain of 5% or more in the last month or gain of 10% or more in last 6 months, received a diuretic (help remove extra fluid from the body), and diagnoses included hypertension (high blood pressure) and dyspnea (shortness of breath).R54's care plan dated 5/8/26, indicated potential for fluid imbalance R/T (related to) use of diuretic medications due to edema (swelling) and interventions included monitor for S/S (signs and symptoms) of fluid retention; increasing edema, puffy face, increased weight, dyspnea, increased coughing, wet sounding cough, bounding pulse, increased blood pressure and notify MD (medical doctor) as needed. R54's weights indicated:4/1/26 at 12:16 p.m., 213.0 lbs. (pounds)5/1/2026 at 2:55 p.m., 208 lbs. 6/2/26 10:19 a.m., 219.0 lbs. (5.29% weight gain from the previous month)On 6/23/26 at 8:44 a.m., licensed practical nurse (LPN)-A stated resident's weights were obtained by nursing assistants (NAs) on paper, provided to the nursing staff for entry into the electronic medical record (EMR). The nursing staff provided documented paper copy of the weights to the resident care coordinator (RCC) and weight concerns would be reported to the RCC. LPN-A confirmed R54 experienced a weight gain in June 2026 compared to the previous month and stated physician notification would be expected for the weight gain.On 6/23/26 at 9:50 a.m., registered nurse (RN)-A, known as the RCC, reviewed the R54's weight records and confirmed R54 on 5/1/26, weighed 208, and on 6/2/26 weighed 219. RN-A confirmed the 11 pound weight gain was a significant weight gain and stated a weight gain of more than five pound in one month required follow up. RN-A stated physician notification, dietitian notification, family notification, and evaluation of the resident's condition would be expected. RN-A confirmed there was no documented reweigh and no evidence the physician had been notified regarding the significant weight gain.On 6/23/26 at 10:34 a.m., director of nursing (DON) stated following identification of the R54's weight gain on 6/2/26, expectations would have included obtaining a reweigh, assessing for edema and lung sounds, evaluating for fluid retention, and notifying the physician regarding the change in condition.On 6/23/26 at 1:10 p.m., registered dietitian (RD)-B stated they had been employed at the facility for approximately two weeks and had not reviewed R54's weight gain because they were not employed at the facility when the weight was obtained. RD-B stated nursing staff were expected to communicate significant weight changes to the dietitian and physician for evaluation and follow-up.On 6/23/26 at 3:14 p.m., dietary manager stated nursing staff were expected to communicate significant weight gains greater than three percent in one month to the dietary department for evaluation and follow-up.Facility Weight Management Policy/Procedure dated 1/25, indicated; Residents weights are taken and entered into their electronic medical record.The RN Resident Care Coordinator is responsible for reviewing weights and determining the need for immediate reweights for verification and notification of physician, dietician and family for weight change that meets criteria as listed below. Trigger for weight gain concern include a 5% or greater weight gain in 30 days.

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.

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure physician orders and interventions were followed for pressure ulcer (PU) wound care and healing for 1 of 2 residents (R9) reviewed for pressure ulcers.Findings include:R9's face sheet printed 6/23/26, indicated diagnoses of presence of artificial knee joint, anxiety, arthritis, and rash or nonspecific skin eruption.R9's care plan dated 1/15/26, indicated resident at risk for impaired skin integrity and pressure ulcers as evidenced by diagnosis of diabetes, edema, impaired mobility, need for assistance with repositioning. Has unstageable pressure ulcer on right heel. Approach: assisted to reposition every two hours in chair and bed. Float heels with pillow in chair and bed.R9's physician's order dated 3/10/26, indicated suspend right heel at all times until wound heals, every shift. R9's physician's order dated 5/21/26, indicated apply skin prep to right heel and cover with Mepilex (foam bandage) two times per week on Wednesday and Saturday and as needed.R9's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no behaviors or rejection of care, at risk for developing pressure ulcers, and one unstageable pressure ulcer not present on admission.During observation on 6/23/26 at 9:01 a.m., R9 was seated in her recliner with her heels on the recliner footrest. R9's right heel was not suspended on a pillow as ordered.During interview on observation on 6/23/26 at 9:30 a.m., registered nurse (RN)-B stated R9's heel was not elevated off the recliner as ordered. RN-B removed R9's sock and no dressing was present on R9's heel wound. RN-B stated she had not been informed the dressing was not on as ordered and would complete wound care and apply a new dressing. RN-B further stated if no dressing was present, she would expect to be notified and she knew last time she worked there was a dressing on R9's heel wound.During interview and observation on 6/23/26 at 10:06 a.m., RN-C stated R9 should have her heel floated at all times, refused to wear heel boots, but would let staff put a pillow under her leg to elevate her right heel. R9 was seated in her recliner with her heel resting on the recliner footrest. RN-C stated that someone must have forgotten to elevate her heel and proceeded to put a pillow under R9's right leg, allowing the right heel to be suspended in the air. R9 stated it felt good to have her heel elevated and not pushing against the footrest. RN-C stated it was important to have a dressing on and the heel floating as ordered to encourage wound healing. RN-C stated she had been taking care of R9'S heel wound since January, it was improving and the wound care and interventions needed to be followed.During interview on 6/23/26 at 1:10 p.m., nursing assistant (NA)-A stated she had taken care of R9 that morning, was not aware her bandage was not on and did not know why her leg was not elevated on a pillow but knew she had a wound and her heel was supposed to be elevated off the recliner footrest.During interview on 6/23/26 at 1:30 p.m., NA-B stated she was not aware of the missing bandage or that R9's heel was not elevated. NA-B stated it was on R9's care sheet to elevate her right heel.During interview on 6/23/26 at 2:45 p.m., director of nursing (DON) stated she would expect orders for pressure ulcer treatment to be followed as ordered to allow for wound healing.A facility policy titled Skin Ulcer Assessment, Prevention, and Management dated 1/25, indicated pressure relief devices, including pillows, were available and residents who were dependent on staff would have measures implemented to reduce pressure. A physician's order will be obtained for all wound treatments.