

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER St John Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 201 South County Road 5 Springfield, MN 56087	

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)
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>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.</p> <p>Findings include:</p> <p>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)</p> <p>R25's readmission Minimum data set (MDS) dated [DATE], indicated R25 had mild cognitive impairment but understands and is understood.</p> <p>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.</p> <p>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 [DATE] at 3:15 p.m. R25's medical record lacked evidence written notice of the transfer had been provided to R25 or representative.</p> <p>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 arrhythmia (abnormal heart rhythm).</p> <p>R28's quarterly MDS dated [DATE], indicated severe cognitive impairment but understands and is understood.</p> <p>During interview 4/15/24 at 2:28 p.m., R28's family member (FM)-C 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.</p> <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>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.</p> <p>Findings include:</p> <p>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)</p> <p>R25's readmission Minimum data set (MDS) dated [DATE], indicated R25 had mild cognitive impairment but understands and is understood.</p> <p>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 [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>R28's quarterly MDS dated [DATE], indicated severe cognitive impairment but understands and is understood.</p> <p>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 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.</p> <p>During interview 4/15/24 at 2:28 p.m., R28's family member (FM)-C 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.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42073</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 in the facility was cleaning the ice machine according to manufacture instructions.</p> <p>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:</p> <p>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).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>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.</p> <p>NOTE: A Sanitizing Procedure must be performed after all cleaning procedures have been completed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>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.</p> <p>Findings include:</p> <p>R41's diagnosis list printed on 4/17/24, included history of pulmonary emboli (when arteries are blocked by a blood clot).</p> <p>R41's significant change Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment and dependency upon staff for most activities of daily living.</p> <p>R41's physician orders dated 9/8/23, indicated indwelling urinary catheter.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		