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	06/03/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure kitchen and walk-in cooler was clean and free of food-like debris. In addition, kitchen staff failed to consistently log dishwasher temps to ensure proper sanitation and failed to date meat when placed in the walk-in cooler to thaw. This had the potential to affect all 51 residents. Findings include: FOOD STORAGE/KITCHEN CLEANLINESSObservation on 6/1/26 at 10:55 a.m., in the kitchen identified:The stove-top had food crumbs and a dried liquid on and between the burners and the wall behind the stove had food debris splashed upon the wall. A utility box mounted on the wall to the right of the stove was covered with a heavy layer of dust, mixed with food particles.A food prep counter near the sink had a radio that was covered in dust and food debris splatter.The office area connected to the kitchen had a countertop with a microwave, toaster, open partially used container of peanut butter, a large partially used plastic container of butter, and half of a loaf of bread. The countertop also had phone chargers, staff personal drink tumblers, change, a stapler, magazines, clip boards, pens, and other postal mail laying on the counter and on top of the microwave. There was no indication this area was not used for resident food preparation or reheating.Inside the walk-in cooler there was shredded cheese, onion peels, crumbs, and other unknown debris scattered throughout onto the floor. The walls behind the shelving had splatters of an unknown substance and the floor below a shelf (approximately 1-2 feet up the wall from the floor) had a black, spotted, mildew-like substance. The walk-in cooler had a large beef roast on the second to bottom shelf that was contained in a sealed plastic wrap, was soft to the touch and appeared fully thawed. There was also 2 large boxes containing additional beef roasts that were placed in the cooler to thaw that had no date when it was placed into the cooler. The bottom shelf had a ham roast that was also thawing, again, with no date when it had been placed into the cooler. On the upper shelf above the thawing meat listed above, were several cooked chicken legs that were not covered or dated. Next to the chicken was a small steamtable tin left uncovered containing a white creamy substance, that was not labeled with its contents, nor was it dated. There were 4 free standing carts observed against the wall inside the cooler with large clear plastic cover over them. The carts had trays with a variety of items, such as single servings of desserts in small dishes, pureed bread, mixed fruit, glasses of white and chocolate milk, and glasses of juice. On the outside of the cover, the carts were labeled breakfast, lunch, supper. None of the food items on the carts were dated to identify when they had been removed from the original container or when they should be discarded if they were not used. Interview on 6/1/26 at 11:12 a.m., with dietary aid (DA)-A identified he agreed none of the previously mentioned food items had been dated. Dietary staff set up the carts for meal service and he identified some of the items on the carts that were set up yesterday and some of the items were set up today. He was not certain when the beef and ham roasts had been placed in the cooler to thaw and believed the chicken legs in the tin pan had been in the cooler for a couple days. He identified the white creamy substance in the small pan next to the chicken was pureed chicken and agreed the pan should have been covered and dated. Review of the cleaning logs for May of 2026, identified 3 different detailed list of kitchen areas to be cleaned and sanitized such as food prep counters, back splash, appliances, floors, coolers, and garbage. One of the lists noted (continued on next page)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff had completed cleaning duties for 3 of 31 days, another list noted staff had completed cleaning duties for 8 of 31 days. Review of the undated General Food Preparation and Handling policy identified the kitchen was to be neat and orderly, kitchen surfaces and equipment would be cleaned and sanitized as appropriate. Food will be covered when in storage and cooked as soon as possible after thawing. Meats, fish and poultry will be defrosted using safe thawing practices. The policy made no mention of dating foods pulled from the freezer to be thawed. Review of the undated Cleaning and Sanitation of Dining and Food Service Areas Policy identified staff were to:Keep all food service areas clean, sanitary, free from litter, and rubbish.Tasks shall be designated to be the responsibility of specific positions in the department.A cleaning schedule would be posted for all cleaning tasks and staff would initial the task as completed.The director of food and nutrition services would perform inspections of the food service areas to ensure all cleaning and sanitation tasks are being completed.Sanitation inspections would be conducted daily by food service staff and weekly by the dietary manager to ensure the areas are clean and comply with sanitation and food service regulations. DISHWASHERInterview on 6/1/2026 at 11:20 a.m., with DA-B said she was one of the staff who washes dishes. She was not sure if the dishwasher sanitized by heat or chemical, but said that the monitor on the dishwasher says sanitizing and that was how she knew the sanitization was being completed. She said the dishwashing staff were to log the temperatures on the log sheet at each meal service but was not certain of the purpose of that process. She said she puts blue stuff she thought might be a sanitizer in a tub of water that she soaks the dishes in and if it isn't blue enough she adds more. Observation on 6/1/26 at 11:20 of the blue stuff DA-B was soaking the dishes in was not a sanitizer rather it was an enzymatic pre-soak commonly use as an aid to remove debris from dishes. Review of the May 2026 Dishwasher Temperature log identified the dishwasher sanitized through heat, and not chemical had a column for each meal service for staff to log dish wash and rinse temperatures for ensuring proper sanitization of the dishes. For the breakfast service, the temperatures were only logged for 4 of 31 days. for lunch service, the temperatures were logged for 3 of 31 days. The supper meal service, temperatures were logged for 26 of 31 days. Interview on 6/2/26 at 10:20 a.m., with the dietary manager (DM) identified she agreed with the above findings, she had no idea when the ham and beef roasts had been placed in the cooler to thaw and identified she would discard the meat as it was not safe to eat. It was her expectation that staff would date the meat when it was pulled from the freezer. She expected staff to complete cleaning in the kitchen daily and initial the cleaning logs as the duties were completed. The DM said the counter in the office where the microwave and toaster were located had been used to prepare and warm resident food and occasionally was used by staff to make toast for themselves. Interview on 6/2/26 at 10:27 a.m., with the registered dietitian (RD) identified, she comes to the facility every Tuesday. She had been in the kitchen today and agreed with the above findings. She identified she had not completed an audit or walk through of the kitchen since approximately December but had completed one earlier that day after being updated of the concerns noted above. The RD identified following her walk through I definitely need to start doing weekly audits again. In addition, she identified the kitchen needed some deep cleaning and staff would need to be re-educated. The RD said in the office area where the microwave and toaster were, it was not acceptable to be used for preparing food for residents in any area where staff personal supplies were used or stored. She was not aware this was happening until today. She further identified she had directed the DM to discard all the undated meat that was in the walk-in cooler for thawing and that this had been completed. A dishwasher policy and procedure or manufacturer's instructions for use on the dishwasher was requested but not provided by the end of the survey period.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance Program Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 51 residents. Findings include: Review of the designated quarterly QAPI meetings from June 2025 through April 2026 identified facility departments were submitting data for review by the committee, but the minutes lacked evidence of measurable goals, discussion of the data submitted, and a plan of action for improvement. Examples included:The June 18, 2025, QAPI meeting minutes identified the facility monitored areas such as:Falls: 13 falls occurred, which was down from the previous month with 4 residents (unknown) having repeated falls. The goal was to decrease falls. There were no major injuries noted with actions to continue to review each fall and new intervention in place. There was no indication who the residents involved were, if the facility was monitoring those falls to ensure interventions were followed, if there was a need to alter interventions, if potential commonalities with residents and their falls (hours of day, shifts when they occurred, etc.) were reviewed, or how they intended to meet their goal or what the benchmark was.Alarms: Staff noted there was a decrease from the previous month and staff were to continue to attempt to decrease the number of alarms. There was no indication of what the goal was, how the facility would reach their goal, or how they were going to implement their action plan or monitor its progress.Skin: Staff noted they had 2 (residents) with pressure ulcers (PU). QAPI would continue to monitor. There was no documentation to identify what the benchmark and goals were, how the facility would reach their goal, or how they identified they would monitor the PU.Weights: The goal was to improve weight charting and monitor for accuracy. They had noted improvements occurred in charting and they had added a note to the electronic treatment record for the nurse to review and they would continue to monitor. There was no resident specific information noted to have been discussed as to whether or not the weights being monitored were high impact resident risk areas such as severe weight loss with specific residents, or if this was an overall problem with staff obtaining and documenting weights in the treatment record.Antipsychotics: 9 residents were noted to be on antipsychotics. 2 were on hospice. The facility noted they would continue to work on decreasing antipsychotics with the psychiatric provider. There was no indication if QAPI reviewed specific residents to determine if the antipsychotics were appropriately prescribed, if they were being appropriately monitored, and if non-pharmacological interventions had been tried and were appropriate.The July 25, 2025 meeting minutes identified each department area brought forth data to QAPI. Infection control, for example, had listed the number of infections, however there was no evaluation of that data, if the infections had commonalities in surveillance, what goals and benchmarks were, or how the facility was ensuring the infection preventionist was appropriately surveilling the facility. Skin areas were also discussed and were similar to the previous month's review with a lack of documented discussion or data analysis, and antipsychotics were noted with the same goal to decrease their use for residents', but there was no information as to how the facility would reach that goal, or if specifics for residents were discussed. The September 17, 2025, December 2025, March 2026, and April 2026 meeting minutes identified each area [NAME] forth data to QAPI were similar to those minutes above with missing goals, benchmarks for how the facility was performing with other facility's in the State or Nation, if they had reviewed specific residents' circumstances, how they would achieve their goals, if their limited documented actions had been successful from the previous months, if there was a need for change, or how long the facility needed to monitor each area brought forth. The Performance Improvement Project (PIP) for 2026 was moderate to severe pain in long stay residents. There was no data to identify the need for the project, discussion with rational for choosing the project, measurable goals, and development of a plan of action for the project. Overall, there was no documentation in the above-mentioned QAPI (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	minutes to support the QAPI committee set benchmarks or measurable goals, thoroughly analyzed the data brought forward, how they were going to achieve their goals, if further education was needed, or if specific staff required retraining etc. Interview on 6/3/26 at 3:39 p.m. with the facility administrator and director of nursing regarding the QAPI program identified department heads provided data that was included in the meeting minutes, but there was no discussion, establishment of measurable goals, or plan of action developed and documented in the meeting minutes.The Administrator identified the QAPI committee had chosen moderate to severe pain in long stay residents as the 2026 project. She identified the QAPI minutes had no discussion, analysis of data, implementation of an action plan nor a measurable goal established in the five months since the beginning of 2026. Review of the January 2026, QAPI Plan identified the administrator as responsible to ensure the QAPI plan was reviewed at least annually. Revisions were to be implemented to identify and address issues identified in the organization. The facility provided services which impacted care and services to all residents living in the facility community. The committee was to utilize evidence-based practices and data to define goals and implement plans of action. The administrator and DON were designated as having responsibility for leading and directing the QAPI program. Performance Improvement Projects (PIPS) were to have a project charter developed at the beginning of the project that established goals, scope, timing, milestones, team roles, and responsibilities. Information was to be discussed during QAPI meetings with monitoring, analysis of the identified problem, and indication for changes. To promote improvement the organization was to develop actions to address the root cause and contributing factors that would affect the identified issue.

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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. Based on interview and document review, the facility failed to follow physician orders to measure a pressure ulcer weekly and follow their policy and procedure on documenting pressure ulcer care for 1 of 1 sampled resident (R8).Findings include: R8's quarterly, Minimum Data Set (MDS) assessment, accepted on 5/19/26 identified R8's cognition was moderately impaired, and she required substantial assistance with care, bed mobility and transfers. R8 had a life expectancy of 6 months or less and was on hospice. R8 had pain and within the assessment period, had reported her pain was severe. R8 took scheduled pain medication and as-needed pain medication. R8 was identified as having a Stage 2 pressure ulcer with a pressure relieving device in her chair and on the bed. Observation and interview on 6/2/26 at 8:55 a.m., with registered nurse (RN)-A who performed a dressing change to R8's thoracic spine identified RN-A removed the old dressing and cleansed the area. The wound measured 0.7 centimeters (cm) x 0.4 cm. RN-A described the wound as superficial with a red wound bed and well-defined edges. RN-A reported she did not note any signs or symptoms of an infection and applied a new dressing. RN-A stated weekly wound documentation was completed in the progress notes. R8's 11/18/25, physician telephone order identified:Staff were to give Arginaid (wound healing supplement) and mix with a 4-ounce beverage twice a day until the wound resolved.Staff were to change R8'S dressing to her thoracic (upper middle area) spine Tuesday and Saturday morning after her bath and measure the wound on Tuesdays until healed. Review of nursing progress notes from 3/1/26 through 5/31/26 identified there were 5 weeks the facility did not follow the physician orders to measure weekly or document pressure ulcer assessments per policy. For the week of;3/22/26 through 3/28/26, there had been no wound documentation or measurement.4/12/26 through 4/18/26, a note identified on 4/18/26 R8's Mepilex dressing had been removed and a new one applied. The note lacked a description or measurement of the wound. 5/3/26 through 5/9/26, a note identified on 5/3/26, a treatment had been done to R8's mid back and a new foam dressing had been applied, with no drainage noted. The note lacked a description or measurement of the wound. On 5/9/26, a progress note identified a new foam dressing had been applied to bony prominence of mid back, with no signs or symptoms of infection. That note lacked a description or measurement of the wound.5/17/26 through 5/23/26, a note identified on 5/23/26, that no redness or edema was noted. A new foam dressing had been applied to R8'S mid back, showing no signs or symptoms of infection. The note lacked a description or measurement of the wound.5/24/26 through 5/30/26, there had been no wound documentation or measurement. Interview on 6/3/26 at 10:35 a.m., with RN-C identified, the nurse should be documenting and measuring a pressure ulcer weekly. Interview on 6/3/26 at 11:40 a.m., with RN-B identified the nurse was to assess and measure R8's wound weekly on her bath day and document that in the progress notes. Interview on 6/3/26 at 2:05 p.m., with director of nursing identified staff were to monitor R8's pressure ulcer weekly and notify the physician if the wound was not improving or was worsening. Her expectation was that R8's or any other resident's pressure ulcer would be assessed weekly with measurements to monitor any need to alter the treatment. Review of the November 2025, Pressure Ulcer/Skin Breakdown Clinical Protocol policy identified the nurse would monitor pressure ulcers weekly. The nurse was to describe and document the pressure ulcer location, stage, length, width, depth, surrounding tissue, and wound bed and document the residents' pain, mobility, current treatments and active diagnoses.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to perform antibiotic stewardship to include a system for monitoring and reducing antibiotic resistance. In addition, the facility failed to follow their policy on antibiotic stewardship and conduct an antibiotic timeout (ATO) for 1 of 3 sampled residents (R52). Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.p identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out. Review of the Resident Antibiotic Tracking forms from February 2026 through May 2026 identified in the section Antibiotic Reassessment (Antibiotic Timeouts) preformed yes or no, was left blank each month. Review of February 2026, Antibiotic Tracking form identified R52 had symptoms of behaviors, incontinence, a fall, and cloudy urine with an onset date of 2/18/26. A urinalysis and culture were completed and R52 was identified as having a urinary tract infection (UTI). R52 started on Ciprofloxacin 500 milligrams (mg) orally twice a day for 7 days starting on 2/19/26 and finishing the antibiotic on 2/25/26 and symptoms resolved on 2/26/26. There was no indication that an ATO had been completed. R52's 2/19/26, physician order identified Cipro 500 mg by mouth for 7 days for UTI. Interview on 6/2/26 at 2:30 p.m., with registered nurse (RN)-D identified the facility kind of completed ATO's. The nurse was to notify the provider if the resident did not seem to be getting better and the nurse would make a note about that. The facility did not have a form or anything that they use, they would just make a progress note. Review of R52's progress notes from 2/15/26 through 2/27/26 identified on:2/15/26, multiple behaviors had been charted.2/19/26, R52 was found on floor at 0030 during routine rounds.2/19/26, at 4:45 p.m., a note identified an order for urinalysis and urine culture. 2/19/26, at 5:14 p.m., a note identified R52 had UTI and received an order for antibiotics.2/20/26, at 11:20 a.m., R52 was sleeping heavily, did not eat breakfast, was toileted and repositioned every 2 hours, sat in the recliner, and had not taken medications.2/20/26, at 1:04 p.m., R52 took bites for lunch and took some of her medications. 2/21/26, at 6:03 a.m., R52 was awake for bath and given last evening's antibiotic.2/22/26, at 6:02 a.m., R52 was awake and took last evenings antibiotic crushed and mixed with ice and grape juice.2/23/26, at 10:49 a.m., R52's culture was noted abnormal, and staff were to continue with current antibiotic, (5 days after starting the antibiotic). 2/27/26, at 8:45 a.m., the antibiotic course was completed for R52's UTI (on 2/25/26). Interview on 6/3/26 at 10:05 a.m., with RN-D confirmed the facility did have any type of form they used to document an antibiotic timeout. The facility did communicate to the physician about culture and sensitivity results. There should be a progress note, but the facility could do better on antibiotic stewardship and let the provider know how the resident was responding to an antibiotic. RN-D revealed the nurse practitioner came to the facility sometimes 3 times a week and could review the antibiotic timeout information on those days. RN-D confirmed that there was no consistent review of antibiotics. Interview on 6/3/26 at 11:00 with RN-C identified the facility did not do any type of ATO's after starting an antibiotic. Interview on 6/3/26 at 11:03 a.m., with RN-B identified as a nurse, she always followed up with the physician after a resident finished an antibiotic. She always tried to follow up with the provider to let them know if the resident symptoms resolved or continued after finishing the antibiotic and did not mention the need to perform an ATO between 48-72 hours after initiation. Interview on 6/3/26 at 2:05 p.m., with the director of nursing identified that she would expect staff would be following their antibiotic stewardship policy and completing ATO's. Review of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the undated, Antibiotic Stewardship policy identified the facility had protocols and systems to monitor antibiotic use. Part of that system included an antibiotic timeout which the nurse would monitor the initiation of an antibiotic and conduct and ATO within 48-72 hours to monitor the response to the antibiotic. The nurse would also review laboratory results and consult with the physician to determine if the antibiotic was to continue or if any adjustments needed to be made. There was no indication the policy had been reviewed or revised annually to ensure it met current standards of practice.