STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns on Fountain Lake	1771 Eagle View Circle Albert Lea, MN 56007

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate level care was provided to 1 of 3 residents (R1) reviewed for activities of daily living. Findings include: R1's admission Minimum Data set (MDS) dated [DATE], identified R1 had moderately impaired cognition, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's care plan, dated 2/28/24, indicated impaired physical mobility related to weakness, impaired balance, history of falls, terminal illness. R1's goals included will participate in transfers and ambulation as able. Interventions included R1 was 1 assist with transfers and transfer belt and walker, was able to walk in room and hall with 1 assist and transfer belt; revision on 3/18/24 added to include second staff to follow with wheelchair when walking. R1's progress note dated 3/22/24 at 12:43 p.m., stated new therapy recommendation from hospice for nursing to continue to transfer with front wheeled walker and gait belt for all mobility and assist second staff to follow with wheelchair. Distance as tolerated. R1's progress note dated 3/29/24 at 6:43 p.m., indicated, [R1] had a significant change of condition within the last 24 hours. [R1] was unable to express wants and needs and unable to verbally communicate, drooling noted on left side of mouth and was staring in one direction. Unable to walk decline in mobility from baseline. [family member] updated and [R1] was sent to emergency room [ER] for evaluation and treatment. R1's progress note dated 3/29/24 at 11:09 a.m., included resident returned from ER and was unable to communicate R1 started on Cefdinir 300 mg (antibiotic) for urinary tract infection. R1's Kardex summary printed 4/16/24 at 7:14 p.m., indicated resident was dependent with 1 assist for transfers and walker. Resident could be up as tolerated with assistance. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's record did not include an assessment or development and implementation of care plan goals and interventions that identified R1's needs after the facility identified a decline in overall health status. During an interview on 4/17/24 at 10:25 a.m., clinical manager (CM)-A stated R1 was up and walking with one assist until revised on 3/18/24 with fall intervention to have a second staff follow with wheelchair when walking R1. CM-A stated she was familiar with R1 and identified R1 was unable to walk or verbalize needs when she had the change of condition and was sent to the hospital on 3/29/24. CM-A stated R1 had returned to the facility on [DATE] and still had not returned to her previous baseline after her change in condition that caused her to go to the hospital. CM-A stated she was unable to locate a comprehensive assessment completed on R1 after the change of condition and her return to the facility. R1 would not have been a one assist for transfers and or mobility after 3/29/24 and could not find changes in R1's care plan or documentation that would have accurately reflected the assistance R1 would have needed for mobility. CM-A stated it is an expectation that nursing staff follow the care plan of the residents but a mobility assessment had not been completed for R1 and R1's care plan was not accurate for her level of care related to mobility and activities of daily living (ADL's) on or after 3/29/24. During an interview on 4/17/24 at 1:37 p.m., director of nursing (DON) stated, R1 would not have been assist of one or been able to walk after her last hospital visit. DON stated there should have been a comprehensive assessment completed on residents who return from hospital visits to re-establish baselines with changes of condition or changes in mobility. DON recognized the need to complete assessments and the facility was already working on a plan for improvement. During an interview on 4/17/24 at 2:23 p.m., administrator stated she recognized the facility needed to work on creating better care plans for residents and had a current performance improvement plan (PIP) in place for care planning in the facility. Administrator stated the reason a PIP was in place for care plans was the management team had already recognized the need for improvement. Administrator stated she would expect nurses to complete a comprehensive assessment when a resident has a change in condition and would expect the care plan to reflect those changes. A facility policy titled Care Planning-Interdisciplinary Team, revision date 3/2022, was provided. The policy indicated the interdisciplinary team was responsible for the development of resident care plans. Implementation and interpretation on the policy included: 1. Resident care plans are developed according to the timeframes and criteria established by S483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: a. the resident's attending physician. b. a registered nurse with responsibility for the resident. c. a nursing assistant with responsibility for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. a member of the food and nutrition services staff. e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45843 Based on interview and document review the facility failed to administer medication per physician order and failed to evaluate and address the medication errors to prevent recurrent medication errors for 1 of 3 residents (R1) reviewed for medication administration. Findings include: R1's admission Minimum Data set (MDS) dated , 2/13/24 identified R1 had moderate cognitive impairment, was able to understand others and be understood, did not have any behaviors or rejections of cares in the assessment period. R1 also had a condition or disease with a life expectancy of less than 6 months. R1's March and April 2024 medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per 1 milliliter (ml) (mg/ml) solution, sublingual (below tongue) SL / by mouth (PO) give 0.5 ml (1 mg) every 4 hours (q4h) for end-of-life comfort. May give PO or SL. Document indicated medication was given three times on 3/3/24 and six times on 4/4/24. R1's March medication administration record (MAR) included the physician order for Ativan 2 milligrams (mg) per milliliter (ml) (mg/ml) solution, by mouth (PO) as needed (PRN) give 0.5 ml (1 mg) every 2 hours (q2h) for anxiety-for end-of-life comfort. MAR documented one dose given on 3/3/24. Facility document titled medication error report dated 4/4/24, indicated errors occurred on multiple am and p. m. the date of error was 4/3/24. Document indicated Ativan 2 mg/ml dose given was wrong, provider had been notified and indicated, ok to give next scheduled dose. Measures taken to prevent recurrence of similar errors was noted to provide re-education and would investigate labeling on bottle and how the order was interpreted. R1's record lacked documentation of monitoring of R1 for response to overdose and/or vital signs taken before next dose was given. Further not evident the facility completed a causal analysis of what lead to the errors and develop strategies to prevent recurrent errors. During an interview on 4/17/24 at 2:56 p.m., director of nursing (DON) stated, she had been informed of the medication error to R1 on 4/4/24 when the nurse who had found the error reported R1 had been getting double the doses of Ativan. DON stated she had been informed the error had happened multiple times but had not been informed who had made the medication errors. DON stated she had not yet investigated, provided education, or put anything in place to prevent similar medication errors from reoccurring. DON indicated in the future she would make sure to investigate and provide education to prevent further medication errors. DON reviewed R1's record and identified monitoring and assessing of R1 had not occurred after the error, but she had inquired if the nurse had informed the provider of the error. The nurse had confirmed they had notified the provider and had been directed to continue with R1's current medication orders unchanged. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 2:23 p.m., administrator stated she would expect nurses to follow the medication administration policy and would refer medication errors to the DON for follow-up and or corrections. Facility policy revised 9/19, titled Medication Error Policy, indicated: A Medication Error Report sheet will be completed on any medication/treatment error involving wrong dosage, wrong time, wrong resident, wrong route, wrong medication, pharmacy error, charting omission, transcription error, or any near miss. The error report will be started and completed as much as possible by the nurse finding the error. The error report will be signed by the person responsible for the error. The person responsible will also complete, Measures taken to prevent the recurrence of similar error(s). The physician or NP will be notified, and sign medication error report. Follow up will be on an as needed basis (labs, vital signs, neuro checks, etc.), depending on the nature of the error. The error will be countersigned by the unit Nurse Manager and given to the Director of Nursing. The Director of Nursing will be responsible for having it reviewed by the Medical Director and pharmacist.