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	08/06/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to comprehensively assess and monitor signs/symptoms of fluid overload and failed to implement interventions including notification of changes to the physician for 1 of 3 residents (R3) who had diagnosis of congestive heart failure (CHF) reviewed for change of condition. Findings include:R3's face sheet dated 8/6/25, identified diagnoses of chronic diastolic heart failure (a condition in which the heart does not pump as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic kidney disease (longstanding disease of the kidneys leading to failure).R3's significant change MDS dated [DATE], identified R3 was independent with transfers, had intact cognition, and received diuretic medication. R3's cardiac focus care plan dated 4/21/25, included the following interventions:-fluid restriction: 2000 milliliters (ml) within 24 hours. -give cardiac medications as ordered.-monitor vital signs (weekly and as needed). Notify physician of significant abnormalities.-monitor/document/report as needed any signs/symptoms of congestive heart failure: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. -weight monitoring daily. R3's physician orders were as followed: -compression stockings on in morning and off at bedtime-start date of 4/23/25.-Daily weights-start date of 4/3/25 .-Fluid restriction of 2000 milliliters (ml) within twenty-four hours-start date of 4/1/25.-Furosemide (diuretic) 20 mg, give two tablets once daily-start date of 4/2/25 with end date of 5/23/25. -Furosemide (diuretic) 40 mg, give one tablet two times per day-start date 5/24/25 with end date of 7/18/25. - Furosemide (diuretic) 20 mg tablets, give three tablets in the morning for congestive heart failure-start date of 7/19/25.-Ipratropium-Albuterol nebulizer (bronchodilators; opens airways to make breathing easier) four times per day for asthma-start date of 4/1/25. -Albuterol sulfate inhaler (bronchodilators; opens airways to make breathing easier)-give two puffs every 6 hours as needed for wheezing-start date of 4/1/25-Albuterol sulfate nebulizer (bronchodilators; opens airways to make breathing easier)-administer three ml every 6 hours as needed for wheezing-start date of 4/1/25. In review of R3's weights from 7/15/25 through 8/4/25, identified R3's weights were taken according to the physician's order except on 7/30/25 and 8/3/25 and identified the following:-7/27/25: 322 pounds-7/28/25: 321 pounds-7/29/25: 321.5 pounds-7/30/25: weight not obtained.-7/31/25: 321 pounds-8/1/25: 319.5 pound-8/2/25: 318.5 pounds-8/3/25: No weight obtained (refused).-8/4/25: 320 pounds Review of R3's record between 7/15/25 through 8/5/25 did not identify that edema monitoring was consistently documented. R3's progress note dated 8/1/25 at 11:41 a.m., identified R3's weight had been trending up over the last three days. R3's lung sounds had slight wheezes, although this is his baseline and does have three plus pitting edema to bilateral lower extremities-although it is his baseline. Today his weight is down two pounds. Will monitor his weight over the weekend and if his weight goes up with get him in for an acute visit and will continue to monitor. R3's record between 4/1/25 through 8/4/25 did not identify R3's goal weight nor baselines of lower extremity edema. Although R3's record dated 8/1/25 identified R3 had bilateral 3+ pitting edema, it did not identify the locations/extent of the edema other than lower extremities. Even though vital signs (heart rate, blood pressure, oxygen saturations) were obtained once and were within normal limits, there was no indication a comprehensive respiratory assessment was completed nor evident R3 was assessed and/or administered an as needed (PRN) breathing treatment for wheezing in accordance with physician orders. Further not evident R3's physician was notified, nor evident monitoring for edema and respiratory assessments were completed until 8/3/25.R3's progress note dated 8/3/25 at 5:45 a.m., identified R3 had three plus pitting edema to left foot as well as swelling to left thigh. R3's right foot had two plus pitting edema. Audible wheezing noted and crackles (abnormal breath sounds characterized by clicking, bubbling, or crackling noise) in bilateral lungs, complaining of feeling tired, breathing fast and unable to catch his breath. R3 was coughing throughout the night and was given an as needed cough syrup. Nurse suggested to R3 that he be sent to the ED for evaluation, however, R3 refused. R3 was educated on the importance of following fluid restriction, elevating legs, and using incentive spirometer. R3's progress note dated 8/3/25 at 11:35 p.m., identified R3 had worsening congestive heart failure symptoms of increased shortness of breath, coughing, bilateral crackles, and bilateral edema to lower extremities. R3 was unable to catch his breath after walking from bathroom to the recliner. R3 was given scheduled nebulizer, given as needed cough syrup

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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 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. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and document review the facility failed to maintain documentation of actual disposition of medications to include: residents name, medication name, strength, prescription number, quantity, date of disposition, and involved staff and method of destruction for 1 of 5 residents (R1) reviewed for medication disposition. Findings include:R1's face sheet date 8/6/25, identified diagnoses of hypertensive heart disease with heart failure (a condition where high blood pressure that causes the heart to weaken), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), prosthetic (artificial) heart valve , presence of a defibrillator (a device that provides an electric shock to the heart to get out of abnormal rhythm), and chronic liver disease (progressive deterioration of the liver). R1's physician orders included:-Torsemide (diuretic) forty milligram (mg) tablet give 1 tablet two times a day related to congestive heart failure. Hold if systolic blood pressure (top number in a blood pressure reading) was less than 100 mmHg. (start date of 5/19/25 through 7/9/25).-Torsemide 40 mg tablet give 1 1/2 (60mg total) tablets two times per day for congestive heart failure. Hold if SBP less than 100 mmHg. (start date of 7/9/25 through 7/17/25). Facility pharmacy email dated 7/31/25, identified pharmacy record of a delivery on 7/9/25 of Torsemide prescription (RX) (# 2399736) containing 96 (20 mg) tablets. During an interview on 8/5/25 at 10:06 a.m., R1's physician (MD) on 7/16/25 discovered R1's 7/9/25 Torsemide prescription cards did not have any doses removed and a previously ordered Torsemide cards of 40mg twice daily were still present in R1's medication storage area. MD removed the cards and instructed nurse to give the cards to the director of nursing (DON) to assist in her investigation of a possible medication error. MD did take photos of the Torsemide cards and sent them to the DON on 7/16/25. Review of photo images of R1's Torsemide prescription that were taken on 7/16/25 identified the following: -Rx: 2369106-two cards of Torsemide 20 mg tablet with directions of take 2 tablets by mouth twice daily with 32 tablets remaining. (dispensed on 5/22/25)-Rx: 2399736 -two cards of Torsemide 20 mg tablets with directions to take 3 tablets by mouth twice daily with 96 tablets remaining. (dispensed on 7/9/25) R1's medication error report dated 7/16/25, identified R1 had been given Torsemide 40 mg instead of the prescribed Torsemide 60mg from 7/9/25 through 7/16/25. During an interview on 7/31/25 at 3:48 p.m., registered nurse (RN)-A stated when a medication is destroyed they complete a medication destruction log which contains the resident name, prescription numbers, quantity of medication destroyed. Once the form is filled out then the medications are place in the Med Safe (a medication disposal system) and then the completed log is scanned into the resident's chart. RN-A stated R1's medical record did not identify that R1's Torsemide was destroyed on the 7/23/25 log. During an interview on 7/31/25 at 3:59 p.m., DON stated after she completed an investigation into R1's Torsemide medication error, she proceeded to destroy four prescription cards into the medication destruction bin called Med Safe, however, did not document the prescription numbers, quantity, and date of the destruction. During a follow up interview on 8/5/25 at 5:06 p.m., DON stated after a discussion with the consulting pharmacist (CPharm) she will be creating a medication destruction log for R1's Torsemide that was wasted, however, will be only including an undetermined quantity she destroyed. R1's medication destruction record dated 7/23/25, included multiple of R1 medications that had been destroyed however, did not identify documentation of the destruction of Torsemide (RX: 2369106 and 2399736). During an interview on 8/6/25 at 4:01 p.m., consulting pharmacist (CPharm) stated all medications that are delivered to the facility are property of the resident. When any medication needs to be dispositioned in the medication destruction bin, a log must be completed to include the resident name, date, prescription number, quantity, signature of staff responsible for the disposition, and the documentation of the medication disposition must be maintained in the resident's record. CPharm stated the DON informed him that R1's torsemide had not been properly documented at the time of destruction and he recommended to document that an unknown amount of R1's torsemide had been destroyed and placed in R1's medical record. Review of the facility's Medication Destruction Policy/Procedure dated 8/25, identified the following:-Non-controlled medications should be recorded in the medical record. A licensed nurse should record the name of the medication, prescription number, amount of medication, and date in the medical record.-Medications that meet criteria will be appropriately disposed of using the MedSafe receptacle that is affixed and permanently placed.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure medications were administered according to physician orders for 1 of 3 residents (R1) reviewed for medication administration. The facility's failures resulted in a significant medication error and an Immediate Jeopardy (IJ) situation for R1 who did not receive an increased dose of Torsemide (treat fluid overload related to heart or kidney disease) ordered by the physician. R1 was admitted to the hospital cardiac intensive care unit (ICU) for worsening congestive heart failure where she remained at the time of the survey. The IJ began on 7/9/25 when staff failed to administer an increased dose of Torsemide as ordered, due to not following the rights of medication administration. This resulted in 11 incorrect doses between 7/9/25 and 7/16/25. The Administrator and Director of Nursing were notified of the IJ on 8/6/25 at 1:22 p.m. The facility implemented corrective action prior to the survey on 7/21/25 to prevent reoccurrence, so the IJ was issued at past non-compliance.Findings include R1's face sheet date 8/6/25, identified diagnoses of hypertensive heart disease with heart failure (a condition where high blood pressure that causes the heart to weaken), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), prosthetic (artificial) heart valve , presence of a defibrillator (a device that provides an electric shock to the heart to get out of abnormal rhythm), and chronic liver disease (progressive deterioration of the liver). R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was taking a diuretic and had moderate cognitive impairment.R1's cardiac focus care plan revised on 3/28/25, identified R1 has congestive heart failure, atrial fibrillation, venous insufficiency, prosthetic heart valve, and a cardiac defibrillator. R1's goals included, will be free of cardiac complications. Corresponding interventions included, fluid restriction of 1500 ml, give cardiac medications as ordered, monitor intake and output, monitor vital signs (weekly and as needed), monitor and document sign and symptoms of congestive heart failure, and weight monitoring daily. R1's physician orders for cardiac management orders included:-Torsemide (diuretic medication) 40 milligram (mg) tablet give 1 tablet two times a day related to congestive heart failure. Hold if systolic blood pressure (top number in a blood pressure reading) was less than 100 mmHg (start date 5/19/25, stop date 7/9/25)-Torsemide 40 mg tablet give 1 1/2 tablets (total of 60 mg) two times per day for congestive heart failure. Hold if SBP less than 100 mmHg (start date of 7/9/25, stop date 7/17/25) -Spironolactone (diuretic medication) oral tablet 25 milligram give 1/2 tablet by mouth in the morning.R1's physician assistant note dated 7/9/25, identified R1 had been seen due to crackles (abnormal breath sounds described as popping, bubbling, or crackling) in lungs and increase weights. R1's Torsemide (diuretic) was increased from forty milligram (mg) twice daily to Torsemide sixty mg twice daily. R1's progress note dated 7/16/25, identified R1's face was edematous, had become short of breath, and oxygen level was 86% (normal range is typically between 95-100%) and needed supplemental oxygen. R1 was seen by in house physician and sent to the emergency department (ED) for evaluation. R1's nursing home physician note dated 7/16/25, identified R1 had been seen due to increased oxygen needs and swelling of the face. R1 had a history of congestive heart failure and had been taking Torsemide (a diuretic) at 40mg twice daily. R1 was seen on 7/8/25 due to an exacerbation of congestive heart failure and Torsemide dose was increased to 60mg twice daily. A chest X-Ray obtained showed pleural effusions and cardiomegaly consistent of congestive heart failure. Since that time, R1's dose had not been increased to 60mg, and had several doses of blood pressure medications held due to blood pressures less than 100 systolic. R1 had not had weights recorded since 7/9/25, but she has gained several pounds since admission in March. R1 was markedly edematous with significant pitting edema to mid back, tense and distended abdomen, facial edema, and increased oxygen needs. R1 had not been receiving increased diuretic doses as ordered on 7/9/25 and needed urgent evaluation in the emergency department. R1's emergency management services (EMS) note on 7/16/25, identified R1 had a new onset of shortness of breath and found to be hypoxic at 86% on oxygen at 2 liters/min (L/min). Nursing staff stated R1 had not been taking her diuretic as suspected to low blood pressure, but staff was unaware of how often R1 took the diuretic. R1 complained of shortness of breath and chest pain. R1 had reported the shortness of breath started the last day or so. R1 also had pitting edema (2+) located in upper legs and abdomen. R1's emergency department (ED) note dated 7/17/25, identified R1 presented to the ED due to increased shortness of breath and increased bilateral leg swelling. R1 was normally on 2 L/min of oxygen via nasal cannula and was increased to 3 L/min due to oxygen saturations at 86%. R1 had not been taking prescribed diuretics due soft blood pressures (hypotension). R1's physical