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	11/06/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on interview and document review the facility failed to notify the physician of neck pain following a fall for 1 of 1 resident (R25) reviewed for accidents. Findings include: R25's facesheet printed 11/6/24, included diagnoses including Parkinsonism (condition that affects movement), pneumonia, atrial fibrillation (the heart's upper chambers beat chaotically and irregularly), displaced fracture of second cervical vertebra (broken bone in the neck region of the spine) and fracture of nasal bones. R25's significant change Minimum Data Set (MDS) assessment dated [DATE], included a brief interview for mental status score of 15 indicating intact cognition, uses walker and wheelchair and is dependent for toileting, dressing, and substantial/maximal help for transfers. R25 does not walk. R25 had one fall with major injury. R25's care plan undated, indicated the resident required extensive assistance assist of one and a gait belt to stand pivot transfer and wears a cervical (C)-collar related to neck fracture per physicians order. R25 is at risk for falls and injuries related to impaired balance and mobility, cognitive impairments and exhibits poor safety awareness and self transfers. Interventions for fall included administer medications, supplements as ordered, complete fall risk assessment on admission and as needed per facility policy, follow facility fall protocol, pharmacy consult to evaluate medications, sign in room reminding to ask for assistance, dycem (non slip material) to wheel chair, reacher, autolock brakes added to wheelchair, chair at bedside when in bed and wheelchair bag for storage. R25's current physician orders included: C-collar on at all times dated 8/14/24. On interview and observation 11/4/24 at 3:24 p.m., R25 was sitting in his wheelchair in his room. R25 had on a rigid C-collar on his neck. R25 stated it seems like a long time ago when he fell and broke neck but still has to wear C-collar. R25 indicated he was reaching for something and fell out of his chair. R25 denied any pain currently. (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

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	11/06/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Post Fall Evaluation dated 8/3/24 at 11:43 a.m., no identifier present who completed the form, indicated R25 had an unwitnessed fall at 11:00 a.m. in his room reaching for an item. R25 had an abrasion to his mid forehead 4 centimeters (cm) by 2 cm and a skin tear to left back of hand. The provider was notified by fax. Wheelchair was unlocked and call light was on when resident found. R25 stated he was reaching for paper on the floor that was out of reach. R25 complained of some mild pain in his right foot. Communication was sent via fax to physician including fall with abrasion to mid forehead 4 cm by 2 cm left open to air. Skin tear to the back of left hand cleansed with normal saline and band aid applied. Resident was reaching for a piece of paper on the floor and fell forward out of wheelchair unwitnessed. Please note fall with head protocol being followed, abrasion to mid forehead left open to air, and is it okay to cleanse skin tear to back of left hand daily with normal saline and apply Band-Aid? R25's nursing progress note by licensed practical nurse (LPN)-H dated 8/3/24 at 3:36 p.m., indicated monitoring resident post fall with head abrasion frontal lobe (forehead). At 3:15 p.m., R25 is complaining of neck pain sitting in wheelchair at the time of examination. Declined tylenol for pain. Gently palpitated cervical spine; resident had no pain with palpitation. Resident unable/unwilling to elaborate on pain. Did confirm it was new since fall. Had no complaints of neck pain on prior vital sign checks or that was noted by the nursing assistants. Checked all four extremities for numbness and tingling and R25 denied. Demonstrated movement and strength; equal. Palpitated muscles on sides of neck and did not complain of pain. Offered cool pack and R25 declined. Offered two times very clearly to have him sent to the emergency room for evaluation of neck fracture due to hitting his head on floor. He said no both times. Stated I just want to lay down. Staff assisted him to lay down and he did complain of pain when doing this even when his head was put back up at 45 degrees. Continue to monitor and offer pain relief. R25's nursing progress note by LPN-H on 8/3/24 at 4:43 p.m., indicated cool packs were applied to cervical spine for complaints of pain post fall. See previous notes. R25's nursing progress note by LPN-H on 8/3/24 at 5:22 p.m., indicated resident continue to state his neck is hurting; explained it may be a muscle sprain from his fall. Has only been 45 minutes since Tylenol was given. Continue to monitor and treat pain with as needed treatments. R25's nursing progress note by LPN-H on 8/3/24 at 10:48 p.m., included following up on neck pain from fall at 11 a.m. today. Resident complaining of more severe pain when he is rolling in bed or with bed mobility. States minimal pain when still. Gave cool pack at 10:05 p.m. for 20 minutes to upper back/lower neck. Resident indicated it helped some. Tylenol last given at 4:40 p.m. Does not have any other as needed pain relieving treatments available. Still denies any pain/numbness/tingling in all externalities. Passed on to night shift to give as needed extra strength Tylenol when able to do so. R25's nursing progress note by registered nurse (RN)-G on 8/4/24 at 7:20 a.m., included resident slept poorly. States has worse pain to posterior (back) of neck, especially with repositioning/turning to sides when changing undergarments. Swelling and hematoma (collection of blood outside of blood vessels due to injury or trauma) to forehead/frontal lob 4 x 2 cm x 0.5 cm depth. Arouses easily and is alert and oriented to self and place. Hand grasps are equal, speech clear. Concern with need for imaging (X-rays) so notified on call physician at 3:10 a.m., who gave order to transfer resident to the emergency department (ER). Notified family member at 3:00 a.m., who gave permission to send. Ambulance called at 3:17 a.m. and transported at 3:35 a.m. (continued on next page)

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	11/06/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ED note 8/4/24 at 9:33 a.m., included diagnosis of fall with abrasion to scalp, fracture of second cervical vertebrae, fracture of orbit (upper face bone), nasal fracture, also with frontal bone fracture (forehead region of the skull). R25's nursing progress note 8/4/24 at 11:15 a.m., indicated R25 was sent to ER for evaluation due to complaints of neck pain on night shift. R25 just returned now, wearing C-collar to be kept on at all times for 14 days. R25 was started on Augmentin (antibiotic) for pneumonia. On interview 11/5/24 at 2:36 p.m., medical doctor (MD)-F, R25's doctor, indicated a fall with neck pain requires evaluation in the ED as soon as possible. Even if the neck pain onset was hours after the fall, the provider should have been notified immediately when he started complaining of neck pain. MD-F stated R25 could have lost mobility or even his life by delaying the immobilization of his neck. On interview 11/5/24 at 3:27 p.m., licensed practical nurse (LPN)-D indicated if someone started complaining of neck pain after hitting their head he would notify the provider immediately and transfer to the ER even if the neck pain wasn't initially present. On interview 11/5/24 at 3:33 p.m., LPN-E indicated the provider should be notified right away if a resident fell and then later complains of neck pain especially if the resident hit their head. On interview 11/5/24 at 3:44 p.m., LPN-F indicated any time a resident complains of neck pain after a fall, the physician should be notified and the resident sent to the ED. On interview 11/5/24 at 4:18 p.m., registered nurse (RN)-E, also identified as nurse manager, indicated the provider was initially contacted when R25 fell , but confirmed the nurse should have notified the physician again when R25 began complaining of neck pain. RN-E added LPN-H did offer to send him to the ED but he refused. On interview 11/6/24 at 10:40 a.m., the director of nursing (DON) after reviewing R25's medical record confirmed the provider should have been notified when R25 began having neck pain. A policy on notification to physician was requested but not received.

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	11/06/2024

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 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** 44630 Based on observation, interview, and document review the facility failed to ensure weekly comprehensive skin assessments with measurements were completed for 1 of 3 residents (R59) reviewed for pressure ulcers. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated [DATE], indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe, dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes, cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), chronic kidney disease; at risk for developing pressure ulcers, two unstageable pressure injuries presenting as deep tissue injury (full thickness skin and tissue loss), treatments included: pressure reducing device for chair and bed and pressure ulcer care. R59's care plan printed 11/6/24, indicated stage two pressure injury (partial-thickness skin loss) on both left and right heels, interventions included: follow facility protocols for treatment of injury, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, s/sx (signs/symptoms)of infection, maceration etc. to MD (medical doctor), pressure relieving/reducing mattress, pressure relieving/reducing chair, cushion to protect the skin while in bed and sitting in chair, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R59's document titled skin only evaluation dated 9/12/24, did not indicate concerns or skin abnormatilities of R59's heels or feet. R59's document titled Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 10/3/24, indicated R59 was not at risk for developing pressure ulcers. R59's progress notes indicated : 10/10/24 at 4:12 p.m., licensed practical nurse (LPN)-A indicated R59 has pressure ulcers on both heels, sent for air mattress and pillow under both feet to elevate heels. 10/24/2024 at 2:59 p.m., LPN-C indicated open areas bilateral heels, diabetic, Rt (right) 2 cm (centimeters) x 4 cm, Lt (left) 4 cm x 3.5 cm, no drainage, Mepilex (absorbent foam dressing) applied, recommendations: to be assessed by wound nurse. 10/28/24 at 4:39 p.m., LPN-B indicated recommendations from nurse practitioner (NP)-A, known as the wound nurse, wound one and two: left posterior heel and right medial heel, cleanse wound, and peri wound with ns (normal saline), pat dry, apply collagen sheet, cover with dry bordered dressing, agreed, and signed by physician assistant (PA)-B. (continued on next page)

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	11/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/05/2024 4:11 p.m., registered nurse (RN)-A indicated R59 and POA (power of attorney) requesting a wound clinic referral to her wound on the right heel. SBAR (situation, background, assessment, and recommendation/request communication) filled out for MD/NP (medical doctor/nurse practitioner) to advise/address R59's documents titled Skin Check indicated: 10/10/2024 at 4:00 p.m., LPN-A new skin issue left heel, pressure ulcer / injury, acquired in-house, not painful, length: 4 cm width 4.5 cm depth 0 cm; right heel issue type stage two pressure ulcer / injury - partial thickness skin loss with exposed dermis. wound acquired in-house, wound is new, no signs and symptoms of infection, not painful, length 3 cm width 2.5 cm depth 0 cm, additional care: heel suspension / protection device. 10/12/2024 at 1:14 a.m., RN-A indicated left heel pressure ulcer / injury, wound acquired in-house, not painful, length 4 cm width 4.5 cm depth 0 cm, right heel pressure ulcer / injury, stage two partial thickness skin loss with exposed dermis, wound acquired in-house, length 3 cm width 2.5 cm depth 0 cm, heel suspension / protection, additional care: air flow pad, skin loss with exposed dermis (middle layer of the skin), boggy, additional care: heel suspension/ protection device, air flow pad. 10/24/2024 at 2:41 p.m., LPN-C indicated left heel pressure ulcer / injury, unstageable pressure injuries presenting as deep tissue injury, wound acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful, 4 cm length, 3.5 cm width, 0.1 cm depth, granulation (development of new tissue): 20%, slough (shedding dead surface cells from the skin): 80%, surrounding tissue: dry / flaky, cool, dressing saturation: none, cleansing solution: normal saline, primary dressing: hydrocolloid (moisture-retentive dressings), right heel pressure ulcer / injury unstageable pressure injuries presenting as deep tissue injury, acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful: yes, medicate prior dressing change, 2 cm length, 4 cm width, 0.1 cm, cleansing solution: normal saline, primary dressing: foam, additional care: heel suspension / protection device. 11/05/2024 at 4:37 p.m., RN-C, known as the nurse manager, indicated skin is pale in color, skin is fragile, normal skin turgor, medial left heel, stage two pressure ulcer / injury, partial thickness skin loss with exposed dermis, wound acquired in-house on 10/10/2024, no signs and symptoms of infection, painful with dressing change, medicate prior dressing change, length 4.8 cm, width 4 cm, depth 0.2 cm, epithelial: 20%, slough: 20%, eschar: 60%, moderate sanguineous exudate, surrounding tissue: maceration; stage two right heel pressure ulcer / injury partial thickness skin loss with exposed dermis wound acquired in-house 10/10/2024, no signs and symptoms of infection, painful at dressing change, length 1.5 cm, width 1.5 cm, depth 0.2 cm, epithelial: 50%. granulation: 30%, slough: 20%, peri wound: rolled edge surrounding tissue: maceration. edema: no swelling or edema, skin issue education: change clothing / briefs, turn every two hours. (continued on next page)

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	11/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's visit report document dated 10/25/24, RN-D, wound care nurse, indicated wound one: left, posterior heel is a stage two pressure injury/pressure ulcer acquired on 10/24/24, and has received a status of not healed, initial wound encounter measurements are 4 cm length x 3.5 cm width x 0.1 cm depth, with an area of 14 sq (square) cm and a volume of 1.4 cubic cm moderate amount of drainage, wound bed has 1-25 %, granulation, 76-100% epithelialization, no slough and no eschar present, DTI (deep tissue injury) present, autolytic debridement performed; wound two right, medial heel is a stage two pressure injury pressure ulcer acquired on 10/24/2024, and has received a status of not healed, wound encounter measurements are 2 cm length x 4 cm width x 0.1 cm depth, with an area of 8 sq cm and a volume of 0.8 cubic cm, moderate amount of drainage noted, wound bed has 26-50%, granulation, 26-50% slough, 1-25% epithelialization; wound #1 - left, posterior heel - pressure ulcer cover wound with bordered super absorbent 3.5 (inches) x 4 (inches) every day for 25 days; wound #2 - right, medial heel - pressure ulcer cover wound with bordered super absorbent 3.5 x 4 every day for 25 days apply wound with collagen sheet 2 x 2 every day for 25 days. R59's treatment administration record (TAR), dated 10/1/24-10/31/24, skin check on bath day: document any bruise, rash, or open area. On 10/17/24, the TAR documentation indicated a 5, which indicated hold/see progress notes. R59's progress notes failed to indicate a documented comprehensive skin check. R59's TAR dated 11/1/24-11/30/24, indicated weekly wound assessment B/L(bilateral lower heels every day shift every Saturday with a start date of 11/2/24. R59's TAR date 11/2/24, was blank and documentation in R59's chart of a weekly wound assessment was found for 11/2/24. On 11/5/24 at 8:34 a.m., R59 was lying on an air mattress in bed on and positioned on her back, with foam cushioned boots. R59 stated she was a diabetic and had ongoing problems with her feet, had an amputated toe, and recently broke her ankle prior to coming to the facility. R59 stated she had sores on her heels due to diabetes. R59 verified she wore cushioned boots in bed and while in the wheelchair, and staff repositioned her in bed. On 11/5/24 at 8:34 a.m., nursing assistant (NA)-A and NA-B stated R59 always wore cushioned boots. NA-A stated R59's heels were also floated while in bed. NA-A and NA-B were observed to provide morning cares for resident and removed boots and when morning cares were complete cushioned boots were replaced and R59 was transferred to the wheelchair. NA-A stated the NA's were responsible to inform the nurse when residents had changes in the skin. On 11/5/24 at 11:24 a.m., RN-C, known as the nurse manager, confirmed R59 had bilateral heel pressure ulcers acquired at the facility. RN-C stated the heel ulcers were discovered on 10/10/24, and further stated R59 had a decline in health prior to admission to the facility. RN-C stated R59 at times would refuse position changes, and R59 would not want to get out of bed some days. RN-C stated interventions included cushioned boots and floating heels. RN-C confirmed a comprehensive skin assessment was not completed weekly as expected after 10/10/24, and stated the next weekly assessment was 10/24/24. RN-C stated R59's wound had not worsened and were unavoidable due to her decline in health, and refusal for repositioning. (continued on next page)

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	11/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/24 at 1:38 p.m., RN-D, facility consulting wound nurse, stated she came to the facility and completed wound care on residents. RN-D stated weekly comprehensive skin checks were expected and documented by the facility. RN-D stated with R59's diagnoses, medications, and poor perfusion the pressure ulcers were most likely not avoidable. RN-D further stated without further diagnostic tests hard to determine if the wounds were pressure related or related to poor blood flow. RN-D stated due to comorbidities, decline in health and diet, put her at risk for skin breakdown. On 11/5/24 at 4:33 p.m., R59 was seated in a wheelchair at dining table with cushion boots on feet. On 11/6/24 at 9:26 a.m., the director of nursing (DON) and administrator stated weekly skin checks were expected and documented and confirmed the weekly skin check after 10/10/24, was not completed until 10/24/24. The DON stated pressure ulcers should be measurement weekly with a comprehensive assessment. The DON stated wounds were discussed during IDT (interdisciplinary team) meetings. The DON stated R59 was at risk for pressure related concerns due to her diagnoses. On 11/6/24 at 11:09 a.m., PA-C stated R59 was prone to skin break down due to comorbidities including diabetes, and stated the facility was expected to complete weekly comprehensive wound assessments that included measurements. On 11/06/24 at 11:38 a.m., LPN-B confirmed R59 had bilateral heel ulcers and confirmed weekly comprehensive skin assessments with measurements were expected weekly, and stated she was aware that R59 had skin assessments that were not documented to include the measurements and comprehensive description. The facility Pressure Injury policy dated 9/2019, indicated: To provide appropriate assessment and prevention of pressure injuries, as well as receive the necessary treatment and services to promote healing, prevent infection and prevent any new pressure injuries from developing. Based on the resident's Comprehensive Skin Assessment, St John's will utilize prevention and assessment interventions to assure that a resident entering the center without pressure injuries does not develop a pressure injury unless the resident's individual clinical condition demonstrates that this was unavoidable, and this information will be documented in the medical record. Upon noticing a pressure injury, complete a Wound Assessment and Braden Scale in the EMAR under assessments. Add an order to complete a Wound Assessment in the EMAR weekly. Start interventions as ordered/needed. Notify PCP or in-house NP of new pressure injury. Notify family of new pressure injury. Notify dietary of new pressure injury. Consult PCP, in-house NP, Nurse Manager, visiting wound nurse or Wound Clinic as needed for treatment. (continued on next page)

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	11/06/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complete a new Wound Assessment Weekly. Document weekly and PRN in the Interdisciplinary Nursing notes on the size, drainage, odor, pain, surrounding tissue, and treatment. Review at IDT meetings. When area is fully healed, update Plan of Care, PCP, and document in the Interdisciplinary Nursing notes

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	11/06/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on interview and document review the facility failed to act upon the consultant pharmacist's recommendation for 2 of 5 residents (R55, R59) reviewed for unnecessary medications. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated [DATE], indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe, dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), and chronic kidney disease. R59's document title Medication Regimen Review Report dated 9/21/24, consulting pharmacist (CP)-A indicated potential medication need: R59 with diabetes mellitus type one and CKD3 (chronic kidney disease stage 3) does not receive ACEI/ARB (angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy is a combination of two types of prescription medications that are commonly used to treat a variety of conditions therapy including chronic kidney disease), presence of albuminuria (sign of kidney disease and means that you have too much albumin in your urine) is unknown from records, no allergy/intolerance to ACEI/ARB noted in records. Recommendation: please follow-up on whether ACEI/ARB therapy is indicated for this individual. Order clarification: order for ASA (aspirin) 81 upon admission of 8/12/24, no indication for use nor stop date if applicable. On 11/6/24 at 11:30 a.m. R59's paper chart was located in the nursing station and included the CP-A's recommendation dated 9/21/24. R59's provider and nursing orders were reviewed and lacked documentation the facility had addressed CP-A recommendations. On 11/6/24 at 11:48 a.m., registered nurse (RN)-C, known as the nurse manager stated CP-A emailed the director of nursing (DON) with resident pharmacy recommendations. RN-C stated she was not part of the pharmacy recommendations process, and confirmed R59's recommendation dated 9/21/24, was not addressed as expected. On 11/6/24 at 12:02 p.m., the director of nursing (DON) stated she received a monthly email from CP-A with resident's pharmacy and medication recommendations. The DON stated the email was forwarded to the health unit coordinator (HUC)-D who printed the recommendations and placed a hard copy of the pharmacy recommendation for the provider to address when next at the facility. The DON stated the provider was expected to address the pharmacy recommendations, and further stated she was responsible to ensure pharmacy recommendations were addressed. The DON confirmed R59's pharmacy recommendations dated 9/21/24, were not addressed as expected by the provider. 40614 (continued on next page)

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	11/06/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, required maximal to moderate assistance with toileting, transfers and walking. Medications included anticoagulant, antidepressant, diuretic, anticonvulsant, and hypoglycemic. Active diagnoses included fractures, atrial fibrillation, heart failure, anemia, hypertension, renal insufficiency, diabetes, and chronic obstructive pulmonary disease. No psychiatric/mood disorder was indicated including anxiety or depression. R55's Medication Regimen Review Report dated 6/24/24, CP-A indicated potential medication need: R55 is taking duloxetine (antianxiety, antidepressant medication) with indication of cognitive impairment as diagnosis, is inappropriate. Please link to an appropriate indication, or clarify with a provider if no indication for use has been issued. A progress note from pharmacy consultant dated 7/30/24, indicated medical record reviewed (MRR) with no concerns reported. A progress note from 9/10/24, included indication for duloxetine requested previously and this is second notice due to non-response. Inappropriate indication of cognitive impairment is currently linked to this agent. A progress note dated 10/20/24, included duloxetine inappropriate indication for use. This is 3rd notice issued. Administrative nursing staff emailed to ensure this is resolved. R55's provider orders last signed 10/23/24, by medical doctor (MD)-F, included duloxetine delayed release particles 30 mg one capsule one time a day for cognitive impairment. Initial order date of 6/5/24. On interview 11/6/24 at 12:47 p.m., RN-C, known as the nurse manager stated she is not involved in pharmacy reviews and added the director of nursing and the health unit coordinator (HUC) is responsible for those. On interview 11/6/24 at 12:56 p.m., the DON indicated it is the responsibility of both nurse managers to get the pharmacy recommendations completed. The DON then clarified stating RN-C started her employment in August 2024 and hasn't been trained on pharmacy reviews yet. The DON stated the pharmacy recommendations are electronically mailed (email) to her. The DON stated she does remember getting an email about R55's duloxetine recommendations but had not acted on the recommendation at this time. On 11/6/24 at 12:05 p.m., a phone call was placed to CP-A and a voicemail was left and return phone call was not received from CP-A. Facility Medication Regimen Reviews policy dated 5/19, indicated: The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. (continued on next page)

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	11/06/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: medications ordered in excessive doses or without clinical indication; medication regimens that appear inconsistent with the resident's stated preferences; duplicative therapies or omissions of ordered medications; inadequate monitoring for adverse consequences; potentially significant drug-drug or drug-food interactions; potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences; incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: the resident's name; the name of the medication; the identified irregularity; and the pharmacist's recommendation. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences.

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	11/06/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50761 Based on observation and interview, the facility failed to maintain holding temperatures for hot foods of 135 degrees Fahrenheit or greater. In addition, the facility failed to ensure dietary staff followed appropriate infection control practices during food prep and meal service in the kitchen. This had the potential to affect 22 of 22 residents residing on the unit. Findings include: On 11/4/24 at 5:14 p.m., during observation, two baking sheets of cooked cheese quesadillas were sitting on the stove top, one tray completely covered, and one partially covered with aluminum foil. Surveyor asked cook (C)-A to re-temp the cheese quesadillas approximately five minutes after removing them from the oven and leaving one baking sheet partially uncovered. Cheese quesadillas were temped at 136 degrees Fahrenheit on initial removal from the oven and dropped to 127 degrees Fahrenheit on recheck. On 11/4/24 at 5:20 p.m., during interview with the culinary services manager (CSM) stated that she would not expect the quesadillas to be out of the oven and cooling down partially uncovered. The cheese quesadillas should have been in the oven on warm to hold the appropriate temperature for the resident's food. The culinary services manager stated the cheese quesadilla's will now need to be warmed up in the microwave before the residents receive their meal. On 11/4/24 at 5:22 p.m., during interview, C-A stated the quesadillas should have been kept in the oven on warm and recognized the potential for the quesadillas to cool down by leaving them on stove top partially uncovered. On 11/5/24 at 9:02 a.m., during observation, C-B prepared bacon for breakfast and placed it in a frying pan on top of the stove. The frying pan of bacon was kept on the warm burner via stove top without a lid/cover. On 11/5/24 at 9:05 a.m., during observation, C-B took the bacon temperature while it was on the warm burner (already cooked) and the holding temperature was 119.9 degrees Fahrenheit. On 11/6/24 at 11:40 a.m., during interview, the CSM stated foods that are hot need to be held at 165 degrees Fahrenheit and reheated to 165 degrees Fahrenheit. After looking on a cell phone, the CSM stated the quesadillas and bacon should have been held at 135 degrees Fahrenheit and acknowledged the foods prepared in the 3rd floor kitchen were not at adequate holding temperatures despite the food being cooked. Facility Food Temperatures policy undated, indicated all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items may not fall below 135 degrees Fahrenheit after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit prior to serving. (continued on next page)

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	11/06/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Control On 11/4/24 at 5:16 p.m., during observation, C-A was cutting a cheese quesadilla with a pizza cutter, initially C-A did not have gloves on. After touching the quesadillas with bare hands, C-A realized gloves were needed and stopped what C-A was doing to don gloves before continuing food preparation. The cheese quesadilla was not discarded. On 11/4/24 at 5:25 p.m., during observation, C-A placed fingers inside of a soup bowl, where food had the potential to be in contact with the same surface, removed a quesadilla from the microwave, and proceeded to cut the quesadilla without washing hands and/or donning gloves. On 11/4/24 at 5:29 p.m., C-A and another staff member collided in the kitchen. This incident caused C-A to drop a glass bowl of peaches. C-A proceeded to sweep up the broken glass bowel and peaches with a broom and dustpan, grabbed a cardboard box out of the garbage can in the kitchen and placed it on the floor, dumped the broken glass and peaches from the dustpan into a clear garbage bag and then placed the garbage bag in the cardboard box. Further, C-A placed the cardboard box (with broken glass and peaches) on the countertop next to the sink. C-A then proceeded to place hands on the serving counters and did not wash them or use alcohol-based hand sanitizer. Finally, C-A took the cardboard box of broken glass and peaches to the appropriate garbage. C-A did not wash hands after bringing the cardboard box to the garbage and proceeded to take a clean skillet pan out of the cupboard, put the aluminum foil back over the quesadillas, and placed the quesadillas back into the oven on warm. On 11/4/24 at 7:30 p.m., during interview C-A stated hands should have been washed after removing the garbage from the kitchen and before preparing food/removing pans. On 11/6/24 10:36 a.m., during interview the director of nursing (DON) stated staff need to re-educated on infection control immediately. The DON further stated infection control concerns have the potential to affect all residents living on that unit. On 11/6/24 11:44 a.m., during interview the CSM stated education has been started for the dietary staff. Facility Hand Hygiene policy undated, indicated hand hygiene is the most important single procedure for preventing the spread of infection. Hand hygiene is known to reduce patient morbidity and mortality from healthcare acquired infections. Hand washing with soap and water whenever hands are visibly dirty, before eating, and after using the restroom. The facility's hand hygiene policy also indicated general indications for alcohol-based hand sanitizer that include after touching a resident or resident's immediate environment, contaminated surfaced, and immediately after glove removal.

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	11/06/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation and interview, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R54) when his urinary drainage bag was observed laying on the floor. Further, loose, and contaminated laundry was observed having been sent down the laundry chute without being secured in a laundry/plastic bag. This had the potential to affect all 68 residents who resided in the facility. Findings include: R54's facesheet printed on 11/6/24, included diagnoses of dementia, benign prostatic hyperplasia (an enlarged prostate gland that causes urinary difficulty), and retention of urine. R54's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R54's BIMS (brief interview for mental status) score was 99 indicating R54 could not complete the interview. R54 had clear speech, could usually understand, and be understood. R54 had an indwelling urinary catheter. R54 was dependent on staff for activities of daily living. R54's physician orders dated 8/22/24, included urinary catheter: 16F (French) 10 cc (cubic centimeter) balloon for BPH (benign prostatic hyperplasia) with obstruction and urinary retention. R54's care plan dated 8/22/24, indicated R54 had a foley (a type of urinary catheter) indwelling catheter related to BPH with obstruction, and to connect to leg bag during the day and gravity drainage bag at night. Position catheter bag and tubing below the level of the bladder and away from entrance room door. During an observation on 11/6/24 at 8:58 a.m., R54 was in bed with his eyes closed. His entire urinary catheter bag was laying on the carpeted floor next to his bed. During an observation and interview on 11/6/24 at 9:19 a.m., the catheter bag was still on floor after licensed practical nurse (LPN)-G exited room after giving R54 medications. Together with LPN-G, returned to R54's room. When asked if it was acceptable to have the catheter bag laying on the floor, LPN-G replied, I wondered that too and I don't think so. LPN-G donned gloves and hooked the catheter bag to the bed frame. LPN-G did not know who placed the bag on the floor and stated she found it in that location when she went into the room to give R54 his medications. LPN-G stated leaving the catheter bag on the floor could cause bacteria to get in the system and cause a UTI (urinary tract infection). During an interview on 11/6/24 at 10:03 a.m., registered nurse (RN)-F who was also the infection preventionist and staff development nurse, stated nursing staff were trained on orientation to make sure urinary catheter bags were not placed on the floor. RN-F stated the catheter bag could not rest on the floor or lay on the floor as bacteria could enter the port and migrate to the resident causing a UTI. (continued on next page)

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	11/06/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/6/24 at 11:14 a.m., RN-C who was also a nurse manager, stated staff were expected to hang the catheter bag on the bed frame and not allow it to rest on or lay on the floor; doing so could result in an infection. During an interview on 11/6/24, at 12:42 p.m., the director of nursing (DON) and the administrator were informed of findings. The DON stated catheter bags were never to be placed on the floor and staff had been trained to hang the bag on the bed frame or other surface to prevent that from occurring. The DON acknowledged a catheter bag laying on the floor could result in a UTI to the resident. Facility Catheter Care (Indwelling) policy with revised date of 3/22, indicated the purpose of the policy was to prevent infection. The policy did not include proper positioning of a urinary drainage bag and/or to keep the bag off the floor. LAUNDRY During an interview on 11/5/24 at 8:51 a.m., laundry aide (LA)-B stated resident linens were sent to the basement via a laundry chute located on each floor. Resident's personal clothing were done in unit laundry rooms. During an observation on 11/6/24 at 7:38 a.m., in the basement, the small room where laundry was deposited via laundry chutes from three floors was observed. The room had two yellow carts on wheels, positioned side by side. The carts were full of plastic bags of linen. In addition to the plastic bags, were loose towels and cloth gowns. On the floor were small pieces of maroon colored fabric resembling napkins. During a telephone interview on 11/6/24 at 8:06 a.m., facilitated by environmental services director (EVS)-H, laundry coordinator (LC)-H stated linens placed down the chute should be bagged. During an observation on 11/6/24 at 8:09 a.m., with EVS-H, together observed the laundry chute room. The cloth napkins had been picked up off the floor and were in one of the carts. EVS-H acknowledged the loose towels and gowns in the carts, along with the plastic bagged linens. During an interview on 11/6/24 at 8:21 a.m., LA-B admitted staff did not always bag the linen - they were supposed to but were probably in a hurry and just tossed them down the chute. LA-B stated she usually saw loose towels, gowns, and washcloths; blankets and sheets were usually bagged. During an observation on 11/6/24 at 8:26 a.m., observed linen and garbage chutes on third floor across from the service elevator. There was no signage to inform staff not to place loose laundry down the chute. During an interview on 11/6/24 at 8:30 a.m., community assistant (CA)-C stated she threw loose linen, like towels down the laundry chute, adding that linen only needed to be bagged if there was biohazard or fecal material on them. During an interview on 11/6/24 at 9:14 a.m., CA-D stated linen should be placed in a plastic bag first before putting it down the chute, adding she was aware that sometimes staff threw laundry down the chute that wasn't bagged. (continued on next page)

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	11/06/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview 11/6/24 at 10:02 a.m., RN-F, who was also the infection preventionist, was informed of findings and stated staff were not supposed to throw loose linen down the laundry chute in order to prevent the potential spread of infection. During an interview on 11/6/24 at 12:42 p.m., the director of nursing (DON) and administrator were informed of findings. The DON stated staff were aware to put linen in a plastic bag first before putting it down the chute; that it was an infection control concern if staff were carrying contaminated linen against their uniform. The DON stated laundry staff usually informed her when loose linens were being sent down the chute. Facility Soiled Linen Handling and Transportation policy dated 1/2020, indicated the purpose was to prevent contamination of laundry personnel, surfaces, and residents while handling soiled linens. Soiled linens were to be collected and transported in a sealed plastic bag to prevent spread of contaminants. The policy did not include procedure for placing soiled linen down the chute.