Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2022

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428-3118

RE: CCN: 245518
Cycle Start Date: October 27, 2022

Dear Administrator:

On November 16, 2022, we informed you that we may impose enforcement remedies.

On December 19, 2022, the Minnesota Department of and Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 27, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 27, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 27, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by NO DATA, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Therese Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from NO DATA. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 27, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 16, 2022

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428-3118

RE: CCN: 245518
Cycle Start Date: October 27, 2022

Dear Administrator:

On October 27, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 27, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 27, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE HOME	8000 BASS LAKE ROAD NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/24/22-10/27/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		12/17/22

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

Electronically Signed | 11/25/2022

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.

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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ST THERESE HOME	8000 BASS LAKE ROAD NEW HOPE, MN 55428

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section	E 041	This plan and response to these surveys findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an	

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ST THERESE HOME	8000 BASS LAKE ROAD NEW HOPE, MN 55428

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E 041	Continued From page 3 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility ' s Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	E 041	admission of non-compliance with any requirement nor an agreement with any findings. We wish to preserve out right to dispute these findings in their entirety at any time in any legal action. F 041 SS F = Hospital CAH and LTC Emergency Power Our facility ensures and provides emergency backup power through use of generators located in the front entrance for the Care Center. Facility also has a plan for maintaining generator fuel to power the generators during emergency use during shelter in place incidents. Based on the deficient practice, the facility has evaluated the referenced standards for emergency power management to include the necessary documentation to show compliance. Maintenance staff have been educated on the referenced standards for managing the emergency power supply and the documentation requirements The required 36 month 4-hour load test will be performed and documented accordingly to the referenced standards by 12/17/22. Audits by the Plant Operations Director to occur quarterly following re-education to ensure compliance. Results of the audit to be reviewed at the monthly and quarterly QAPI meetings for direction or change as well as timeline for	

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E 041	Continued From page 4	E 041	completion based on compliance. Completion date for the plan is December 17th, 2022.	
F 000	INITIAL COMMENTS On 10/24/22-10/27/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5518178C (MN83082) H5518177C (MN82815) H55184968C (MN86495 and MN86561) H5518179C (MN81927) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		12/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 5 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure call lights were	F 550	F550 SS = D – Resident Rights/Exercise of Rights	

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	245518	A. BUILDING _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 6 responded to in a timely manner for 1 of 1 residents (R128) reviewed for dignity. Findings include: R128's quarterly minimum data set (MDS) dated 10/10/22, identified R128, was always continent of bowel and bladder. Cognition was not assessed. R128 had diagnoses of rheumatoid arthritis, and osteoarthritis. Hearing and vision were adequate, communicates and understands. Extensive assistance of one for toileting. Care plan dated 4/18/22, identified R128 had an activities of daily living (ADL) self-care deficit. She required assistance of two, EZ stand lift to transfer into bed, and extensive assist of one on and off the bedpan. Continuous observation began 10/27/22 at 10:00 a.m. to 11:32 a.m. At 10:00 a.m. R128's call light was noted to be on for 46 minutes per facility call light monitor at nurse's station desk. No staff enterered her room. At 11:15 a.m. R128 stated she had to use the bathroom. RN-G was informed R128 needed the bathroom and her call light had been on for over 40 minutes. RN-G stated staff were all on break. RN-G remained at the medication cart and did not assist R128 to the restroom. RN-C was notified of R128 call light. She and NA-C entered R128's room at 11:30 a.m. with a hoyer lift. During an interview on 10/27/22, at 11:56 a.m. R128. stated it happened "almost every day" and toook "50 minutes" for staff to answer her call light. After meals and breakfast were the worst, around 9:30 a.m. to 10:30 a.m. R128 stated she had colitis and overactive bladder. To "hold it"	F 550	Saint Therese of New Hope affirms that each resident has the right to be free from interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights as required. The facility standards include review of resident call lights to ensure that the residents needs are met timely. Based on the deficient practice, regarding R128s call lights not being answered timely, DON met with the resident to discuss updates to care plan regarding needs. Staff were immediately educated on her preferences as well as the need to respond to her calls timely. All residents with the potential to be affected by the deficient practice have been interviewed regarding their preferences and needs and these have been care planned and addressed in the staff assignment sheets. Staff have been re-educated on call light answering responsibilities as well as the facility dignity, policy, and procedure that affirms that all residents will be treated with respect and dignity. The DON/Designee pulls call lights reports daily and analyzes response times. The call light review is backed with outreach and staff interviews to ascertain root causes of longer wait times and results are addressed to improve individualized resident outcomes as needed.	

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F 550	Continued From page 7 was "uncomfortable" and "not easy". It made her "angry" and she missed "church and so many activities waiting to go to the bathroom." Review of call light indicated: 10/20/22. 03:54:53, response time 30 minutes, 8 seconds. 10/21/22. 07:38:07, response time 28 minutes, 21 seconds. 10/21/22, 07:31:01, response time 24 minutes 16 seconds. 10/27/22, 11:13:02, response time 30 minutes, 35 seconds. 10/26/22.10:30:02, response time 30 minutes, 16 seconds. 10/26/22.10:30:02, response time 30 minutes, 16 seconds. During an interview on 10/27/22, at 1:30 p.m. TMA-A. stated call lights were answered withing 2-5 minutes. However, if it was a two person assist, residents were notified she'd return. Usually within three to five minutes. TMA-A stated breaks were taken one from each hall, leaving 2 aides on the floor with 2 nurses. During an interview on 10/27/22, at 1:40 p.m. NA-B stated staff responded to call lights in a couple minutes. Further, when she wasn't able to respond timely, she would at least ask residents what they needed and would return as quick as possible. NA-B stated some managers help and some don't. During an interview on 10/27/22, at 2:55 p.m. DON stated staff were to answer call lights "promptly". DON stated it would be "a little bit uncomfortable" to have to wait 30 minutes but it would not cause any medical issues. The	F 550	The DON/Designee is responsible for maintaining compliance with this requirement. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. Completion date for the plan is December 17th, 2022.	

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F 550	Continued From page 8 Administrator stated he expected staff to keep residents informed. A facility Dignity policy dated October 2022, stated it is the facility practice to treat each resident with respect and dignity. It identified the facility would respond to requests in a timely manner.	F 550		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess for potential accident related to smoking on facility grounds for 1 of 1 resident (R9) who was reviewed for accidents. Findings include: R9's Significant Change Minimal Data Set (MDS) dated 8/3/22, identified active diagnoses of anemia (low red blood cells), hypertension (high blood pressure), cirrhosis (hardening of the liver), renal Insufficiency (poor kidney function), hyperlipidemia (too many fats), osteoporosis (weakened bones), and non-Alzheimer's dementia (decreased memory and decision-making ability).	F 689	F689 SS = D – Free of Accidents Hazards/Supervision/ Devises It is the policy of Saint Therese of New Hope to ensure that residents' environment remains as free of accidents/hazards as is possible and that each resident receives adequate supervision and assistive devises to prevent accidents. The policy and procedure for assessing residents for potential accident related to smoking on facility grounds has been reviewed and it remains accurate. R9s was re-assessed for safety related to admittance to periodic/occasional	12/12/22

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F 689	Continued From page 9 R9's Care-plan initiated 7/5/22, failed to identify focus, goal, and interventions for R9 smoking history, or offer cessation program. On 10/25/22, at 10:18 a.m. R9 was lying in bed. R9 stated she chose not to participate in most activities, but rather enjoyed visits from family. R9 stated family often took her outside to smoke on the facility grounds. A progress note dated 10/7/22, at 3:10 p.m. indicated R9 refused to get out of bed. However, R9 got out of bed to go outside with family to smoke. On 10/26/22, at 12:12 p.m. R9 confirmed she went outside with her daughter and smoked. On 10/27/22, at 12:57 p.m. certified nursing assistant (CNA)-A stated no one smoked, it was a smoke free facility. On 10/27/22, at 12:58 p.m. Licensed Practical Nurse (LPN)-A state R9 smoked. He pointed out through dining area window to where R9 has gone to smoke with daughter and verified the bench site was on facility grounds near entrance. On 10/27/22, at 1:12 p.m. Nurse Manager (NM)-D stated facility policy did not allow residents to smoke in the facility or on the grounds. When suspected, a smoking assessment was required. NM-D confirmed R9 lacked a smoking assessment. Further, she acknowledged progress note dated 10/7/22 and H&P notes was enough to require a smoking assessment for R9.	F 689	smoking while at facility to include focus, goal, and interventions for smoking. Cessations programs also discussed. Care plan updated to reflect assessments. All other residents have been re-assessed for potential risks for hazards related to smoking to include focus, goal, and interventions for smoking. Those found to be at risk educated on cessation programs. Care plans updated reflect assessments. Staff re-educated on smoking policy to include interventions and documentation of approaches to assist residents with making safe decisions to eliminate potential hazards. DON/Designees to review resident documentation daily to identify potential concerns, requiring reassessment. Interventions to be implemented immediately to mitigate potential risks. Information to be reviewed by IDT during scheduled meetings. Information to also be covered during scheduled unit huddles. DON/Designee is responsible for maintaining compliance with this requirement. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. Completion date for the plan is December 12th, 2022.	

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F 689	Continued From page 10 On 10/27/22, at 2:00 p.m. Director of Nursing (DON) stated there were no smokers in the facility. When residents wanted to smoke, they needed to go off campus. Residents were offered alternatives, it was a smoke-free facility. DON stated residents with a known smoking history required an assessment to assure quality care. Facility provided policy, Resident Smoking-Smoke Free Facility dated 10/22, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees. A facility-wide "A Smoke Free Facility Policy" was initiated on May 1st, 2008. Section 7 of policy explanation and compliance guidelines states, "Any resident who is exempt from the Smoke Free Facility policy, in accordance with his/her rights to self-determination and participation, will be allowed to smoke in designated smoking areas (weather-permitting) at designated times, and in accordance with his/her care plan." Section 8 under policy explanation and compliance guidelines states, "Residents with a history of smoking will be further assessed to determine whether or not interventions are needed to help cope with the "Smoke Free" policy. Section 9 under policy explanation and compliance guidelines states, "Residents who smoke will be further assessed, using the resident safe smoking assessment, to determine whether or not supervision is required for smoking, or if the resident is safe to smoke at all."	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		11/30/22

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F 732	Continued From page 11 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting. This had the potential to affect all 156 residents residing in the	F 732	F732-SS = C – Posted Nurse Staffing information It is the policy for Saint Therese of New	

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F 732	Continued From page 12 facility and/or visitors who may wish to view the information. Findings include: On 10/24/22, at 4:30 p.m. the facility report of nursing staff direct care was observed on the wall. The posting indicated a census of 156 and included information on scheduled shifts for nursing staff along with the number of staff assigned separated by registered nurse (RN), licensed practical nurse (LPN) and nursing assistant (NA). Each nurse type was further split as number of the staff per shift assigned and actual along with hours scheduled. with actual hours. The posting had the week starting Monday 10/24/22 through Sunday 10/30/22. Each day had the scheduled staff/hours completed. When observed the actual number of staff and hours and census was completed for Monday 6-2:30 p.m. and 2-10:30 p.m. On 10/26/22, at 10:24 a.m. report of nursing staff direct care posting was updated with actual staff/hours or census for 10/25/22 for 2-10:30 p.m. 10-6:30 a.m. or for 10/26/2, 6-2:30 p.m. When interviewed on 10/27/22, at 12:28 p.m. administrator stated staffing completed the posting by 10:00 a.m. with the expectation with census was recorded and posted each shift. When interviewed on 10/27/22, at 12:31 p.m. staff coordinator (SC)-C stated completion of the staff positing depended on which coordinator was there first. Once the schedule was finalized for the next shift the information was updated with actual staff/hours. SC-A, SC-B and SC-C were not aware of why the staff posting had not been	F 732	Hope to publish and post daily staffing hours beginning of each shift visibly for residents and visitors as required by the state law. Based on the deficient the facility will ensure that staffing hours are posted at the beginning of every shift, where residents and visitors can visibly see. The staffing department has been re-educated on the requirements and expectation per policy. The posting will be audited every shift by the DON/Designee to ensure accuracy and details will be brought to the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. Completion date for the plan is November 30th, 2022.	

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F 732	Continued From page 13 completed for the missing shifts. Facility policy Nurse Staff Posting dated 10/2022 indicated the facility posted the nurse staffing sheet at the beginning of each shift.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prescribed medication was appropriately and accurately	F 761	F761- SS = D - Label/ Storage Drugs and Biologicals	12/17/22

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F 761	Continued From page 14 labeled with current physician ordered administration instruction for 1 of 5 residents (R 60) observed during medication administration. Also, the facility failed to ensure that 1 of 2 medication carts observed in the facility were locked when not in direct view of a staff member. This had the potential to put at risk all residents on third floor on hallway one. In addition, the facility failed to ensure opened liquid medication was properly labeled with an open date. This had the potential to affect newly admitted residents. Finding include: On 10/26/22, at 7:26 a.m. registered nurse (RN)-C prepared medication for R60 in the hallway by the nurse's desk. RN-C stated R60 took medications orally now. R60's medication blister pack (card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles) indicated famotidine tablet 20mg (milligram) take one tablet per g-tube (gastrostomy tube, is a surgically placed device used to give direct access to the stomach for supplemental feeding) daily, sertraline 50mg tablet take one tablet per g-tube daily, quetiapine 25mg tablet take one tablet per g-tube twice daily. On 10/26/22, at 7:30 a.m. RN-C stated R60's physician medication orders were changed to orally on 9/28/22. RN-C stated the blister packs did not have a change of direction sticker on them. RN-C stated there should be a change of direction sticker on each blister pack of R60's medication. RN-C stated the sticker should be on there so there was not any confusion for staff. On 10/27/22, at 8:44 a.m. RN-A stated staff	F 761	It is the policy at Saint Therese of New Hope to ensure that drugs and biologicals used in the facility must be labelled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility also expects that health information is protected, and medications are secured in carts with appropriate personnel accessing the medications. The policy and procedure for labeling and storage of medications was reviewed on November 23rd, 2022, and it remains accurate. Resident # 60s medications have been labelled with directions for use. All residents' medications have been reviewed and labelled appropriately. Medications will be reviewed upon delivery and with all medication order changes, a medication change label will be affixed to the label to prompt staff to review the order prior to medication administration. All facility Licensed Nursing were re-educated on the labeling, storage and management of biologicals policy and procedure, health information protection and medication cart locking requirements. Audits will be reviewed one time a week on labeling and storage of medication and biologicals to ensure adherence to the	

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F 761	Continued From page 15 should put a change of direction sticker on the medications if the order had changed. The facility policy, Medication Labels dated 12/19, indicated if the physician's directions for use change or the label was inaccurate, the nurse may place a "change of order-check the chart" label on the container indicating there was a change in directions for use, taking care not to cover important label information. During an observation on 10/27/22, at 8:28 a.m. on the third floor near the nurse's desk, hallway one's medication cart was observed to be unlocked. The computer screen was on and had resident (R62) information in view of anyone who walked past. The hallway one medication cart remained unlocked until 8:31 a.m. RN-C returned to hallway two's medication cart and stated RN-B had not locked the hallway one medication cart and there should not be any resident information left on the computer screen. RN-C locked the hallway one medication cart and put the computer screen to sleep. RN-C stated both should be locked. On 10/27/22, at 8:37 a.m. RN-B stated she should not have left the medication cart unlocked and the computer screen should have been closed. The facility policy Medication Storage dated 4/1/22, indicated all drugs and biologicals will be stored in locked compartments, only authorized personnel will have access to the keys to locked compartments, during medication pass, medication must be under direct observation of the person administering medications or locked in the medication storage area/cart.	F 761	policy and procedure. Medication carts to include securing of resident information will also be audited weekly to ensure compliance. The DON and/or designee is responsible for maintaining compliance with this requirement. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. Completion date for the plan is December 17th, 2022.	

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F 761	Continued From page 16 The facility policy Safeguarding of Resident Identifiable Information dated 10/22, indicated medical records shall not be left in open area where unauthorized persons could access identifiable resident information. Computer screens showing clinical record information may not be left unattended and readily observable or accessible by other residents or visitors. During an observation on 10/27/22, at 11:31 a.m. with RN-D, the medication refrigerator on the west transitional care unit (TCU) contained an open vial of Tubersol (a skin test to aid diagnosis of tuberculosis infection) one ml (milliliter) with a sticker indicating 30 days, there was no date when the vial was opened. The box for the Tubersol had a sticker indicating 30 days but not date the vial had been opened. RN-D stated Tubersol once opened was good for 30 days. RN-D stated there was no date the vial was opened and would need to be thrown away. RN-D stated she was not sure if any residents had received a dose of the Tubersol out of that vial. The vial was one ml and over half full. The facility policy Multi-Dose Vials dated 4/1/22, indicated multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured. The beyond use date rule will begin on the first day the multi-dose is opened or punctured.	F 761		

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE HOME	**8000 BASS LAKE ROAD** **NEW HOPE, MN 55428**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/25/2022. At the time of this survey, St. Therese Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/25/2022

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St Therese Home is a 3-story building with no basement. The building was constructed at four different times. The original building was constructed in 1968 and was determined to be of Type I (332) construction. In 1973, an addition was constructed to the 3rd floor that was determined to be of Type II (111) construction. In 1999, an addition was constructed to the west side of the 1st floor that was determined to be of Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was	K 000		

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K 000	Continued From page 2 determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an existing building of this height, the building is surveyed as one building. The building is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 168 beds and had a census of 157 at the time of the survey.	K 000		
K 225 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress stair enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.2.2.5.1.1, 7.1.3.2.1 (8), 7.1.3.2.3, 7.2.2.5.3, and 7.2.2.5.3.1. This deficient finding could have a patterned impact on the residents within the facility.	K 225	K225 SS = E - Stairways and smokeproof enclosures Door at the bottom of the Care Center employee entrance stairwell has been ordered with a lead time of 6 weeks. Upon delivery, the door will be replaced.	12/17/22

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K 225	Continued From page 3 Findings include: 1. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation that a door at the bottom of the Care Center employee entrance stairwell had been removed. 2. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation that there were two tables with computers on them, a trash can, and wooden boxes on the wall at the bottom of the Care Center employee entrance stairwell. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	K 225	The two tables with employee PPE, the mounted time clocks, the trash cans, and anything else obstructing the area has been removed from the area to comply with life safety code. Plant Operations Director and/or designee to add to weekly environmental audits/rounds to visibly observe stairways and smoke proof enclosures. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. The Plant Operations Director is responsible for compliance with this tag. The date for completion with this tag is December 17th, 2022	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.1.2. This deficient finding could have a patterned impact on the	K 355	K355 SS = E – Portable Fire Extinguishers Action to correct the deficient practice: A facility walk through to account for all fire extinguishers has occurred. All fire extinguishers have been added to the	12/9/22

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K 355	Continued From page 4 residents within the facility. Findings include: 1. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation and document review that the fire extinguisher in the third-floor business office was missing monthly inspections on the tag. 2. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation and document review that the fire extinguisher in the therapy room on the third- floor was missing the monthly inspection for September. 3. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation and document review that the fire extinguisher in the employee break room on the first floor was missing the monthly inspection for September. 4. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation and document review that the two fire extinguishers in the west one hall were missing the monthly inspection for September. 5. On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation and document review that the two fire extinguishers in the west two hall were missing the monthly inspection for September. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	K 355	facility Preventative maintenance schedule for monthly checks and facilities maintenance staff have been educated on new process. Plant Operations Director and/or designee to audit PM for completion of fire extinguishers monitoring monthly Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. The Plant Operations Director is responsible for compliance with this tag. The date for completion with this tag is December 9th, 2022	
K 363 SS=D	Corridor - Doors	K 363		12/9/22

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K 363	Continued From page 5 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363		

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K 363	Continued From page 6 etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation that resident room 315 was held open with a wooden wedge. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	K 363	K363 SS = D – Corridor – Doors Action to correct the deficient practice: A facility walk through all units observing all doors for wedges conducted to ensure compliance. Plant Operations Director and/or designee to add to weekly environmental audits/rounds to visibly observe all doors for any non-compliance with life safety codes. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. The Plant Operations Director is responsible for compliance with this tag. The date for completion with this tag is December 9th, 2022	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		12/9/22

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K 918	Continued From page 7 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 918	K918 SS = F – Electrical system – Maintenance and Testing Action to correct the deficient practice: All campus Emergency Power Supply Systems (EPSS) have been added to Preventative maintenance schedule with required testing schedules per required timeframes of weekly under load 30 minutes, 12 times a year in 20–40-day intervals and exercised once every 36 months for 4 continuous hours. Facilities	

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K 918	Continued From page 8 On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility ' s Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	K 918	maintenance staff have been educated on new process. Plant Operations Director and/or designee to audit PM for completion of EPSS monthly. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. The Plant Operations Director is responsible for compliance with this tag. The date for completion with this tag is December 9th, 2022	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/25/2022 between 09:30 AM and 12:30 PM, it was revealed by observation that there was a	K 930	K930 SS = D – Gas Equipment – Liquid Oxygen Equipment Action to correct the deficient practice: A facility walk through all units observing for unsecured liquid oxygen tanks conducted to ensure compliance. Proper storage mechanism for all cylinders to include those needing to be stored identified. All staff educated on new plan to maintain compliance.	12/9/22

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K 930	Continued From page 9 41 liter liquid oxygen cylinder in the corridor on the second floor near the receptionist desk. An interview with the Plant Operations Director verified these deficient findings at the time of discovery.	K 930	Plant Operations Director and/or designee to add to weekly environmental audits/rounds to ensure compliance with new storage plan of all oxygen cylinders Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. The Plant Operations Director is responsible for compliance with this tag. The date for completion with this tag is December 9th, 2022	