DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C7VC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 31025

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245632**

2.STATE VENDOR OR MEDICAID NO.
(L2) **642487100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST THERESE OF WOODBURY LLC**
(L4) **7555 BAILEY ROAD**
(L5) **WOODBURY, MN** (L6) **55129**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/6/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Sue Miller, HFE - NE II — 11/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 05/22/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/08/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/27/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245632 November 17, 2017

Ms. Kay Emerson, Administrator
St. Therese of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Dear Ms. Emerson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 1, 2017 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 17, 2017

Ms. Kay Emerson, Administrator
St. Therese of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: Project Number S5632001

Dear Ms. Emerson:

On October 4, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2017, effective November 1, 2017 and therefore remedies outlined in our letter to you dated October 4, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2017

Ms. Kay Emerson, Administrator
St. Therese of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: Project Number S5632001

Dear Ms. Emerson:

On November 6, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2017, with orders received by you on October 4, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C7VC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 31025

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245632**
2.STATE VENDOR OR MEDICAID NO.
(L2) **642487100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST THERESE OF WOODBURY LLC**
(L4) **7555 BAILEY ROAD**
(L5) **WOODBURY, MN** (L6) **55129**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Robyn Woolley, HFE-NE II — 10/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 10/27/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/08/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS
Posted 10/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 4, 2017

Ms. Kay Emerson, Administrator
St. Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: Project Number S5632001

Dear Ms. Emerson:

On September 22, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the eletronically attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 1, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 22, 2017 (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). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 22, 2018 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions relating to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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
F 000	INITIAL COMMENTS On September 18 through September 22, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for	F 279		11/1/17

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

Electronically Signed | 10/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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
F 279	Continued From page 1 each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

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F 279	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a preliminary care plan to include interventions to reduce risk of falls for 2 of 3 residents reviewed (R193, R209) for accidents, who were identified at admission as at risk for falls. Findings include: Review of the Pre-Admission Assessment Information form, dated 9/12/17, revealed R209 was being admitted on 9/12/17 with a right hip fracture, and was at risk for falls. R209's face sheet, dated 9/20/17, listed diagnoses including fracture of neck of right femur, and dementia. R209's undated preliminary care plan had a typed note at the top of the form that this preliminary care plan must be initiated "within 24 hours of admission." The document included a section for designating whether or not the resident was a "Fall Risk" by checking either "Yes" or "No", and underneath the boxes was written, "If yes, implement safety measures." The form contained more boxes to check if any of the following safety measures were in place: sensor, grab bars, floor mat, or other safety measure. There was a line next to "other" for staff to clarify any other safety measures in place for R209. Staff had not checked a box to indicate whether or not R209 was a fall risk, and did not document that any safety measures were in place for R209.	F 279	This plan of correction is not an admission of guilt on behalf of the provider. This plan of correction is being submitted because it is required by law. Residents 209 and 193 are no longer at the facility. Residents have a falls careplan initiated within 24 hours of admission; to be completed within 48 hours. The facility□'s policy and procedure regarding falls careplan was reviewed and revised. A comprehensive careplan form was developed and implemented for staff to use for all new admissions. Nursing staff were inserviced on the expectations and requirements of the careplan on 10/11/2017 and will continue until all licensed staff are educated. A new system of careplan binders was developed. The falls careplan will be audited for completion by nursing administration, and/or a charge nurse, 48 hours after admission. 5 careplans/week X4 weeks, 3 careplans/week X4 weeks, 1 careplan/week X4 weeks will be audited. The DON is responsible to ensure that	

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F 279	Continued From page 3 During interview on 9/19/17, at 11:54 a.m. registered nurse (RN)-B said R209 had fallen twice since admission. The first fall was one day after admission on 9/13/17, and the second on 9/17/17. RN-B described the resident as "very confused." During interview on 9/20/17, at 7:48 a.m. nursing assistant (NA)-D thought R209 fell previously, and came to the facility for falls and dementia. During an interview on 9/20/17, at 2:17 p.m. the administrator clarified that the preliminary care plan along with the Pre-Admission Assessment was considered to be the preliminary care plan. On 9/21/17, at 3:20 p.m. the assistant director of nursing said staff tried to keep R209 in the common area to keep an eye on the resident, and kept the call light near the resident in R209's room, but that she could not find fall interventions in writing. Review of the undated policy titled, Care Plans - Preliminary, revealed the following policy statement: "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission." R193 was admitted to the facility on 9/8/17 with diagnoses of history of falling and rhabdomyolysis. R193 had been admitted from a acute care hospital after an unwitnessed fall at home. A review of nursing progress notes, dated 9/8/17,	F 279	falls careplans are developed and initiated. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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F 279	Continued From page 4 indicated resident "had fallen in the past and she is on sedatives which puts her at risk for fall." A review of the Care Plan -Preliminary (initiated within 24 hours of admission) had a yes/no check off box for fall risk and neither was checked off. No safety measures were identified. On 9/20/17 at 1:04 p.m. the interim director of nursing verified the resident was a fall risk and that information should have been added to the initial care plan.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 2 of 3 residents (R59 & R72) in the sample who required assistance with nail care, 1 of 3 residents (R72) who required assistance with oral care and 1 of 3 residents (R59) reviewed for pressure ulcers who required assistance with positioning. Findings include: R59 was assessed to require staff assistance with nail care and did not receive assistance in	F 282	Residents number 59 and 72 receive nail care per the facility policy and standards of care. On 9/21/2017 all resident□s nails were audited by the DON. Resident #72 receives oral care per facility policy and standards of care (in the AM, at HS, and PRN). Resident 59 is turned and repositioned per careplan. All residents requiring assistance with: oral care, nail care, and turning and repositioning will be provided these services in accordance with facility standards.	11/1/17

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F 282	Continued From page 5 accordance with the plan of care interventions. Document review of R59's Minimum Data Set (MDS) dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 required staff assistance for activities of daily living (ADLs). The plan of care for R59 dated 1/1/17, read, "Staff to trim resident's finger and toe nails as needed following weekly bath". Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R59. During an observation on 9/19/17, at 9:11 a.m. R59 had fingernails that extended beyond the finger tips greater than 1/4th inch and appeared dirty with dark tan and brown substance accumulated under each nail. Two of the 10 fingernails had broken side, jagged edges. When interviewed on 9/19/17, at 9:11 a.m. R59 expressed frustration that the fingernails are too long and staff had not offered to clean or trim the fingernails. Furthermore, R59 indicated the substance under the nails was from "food" and feeding self without soaking or cleaning the fingernails for "many weeks." R72 was assessed to require staff assistance with nail care and oral care and did not receive assistance in accordance with the plan of care interventions. Document review of R72's MDS (Minimum Data Set), dated 8/25/17, indicated cognitively intact and the CAA indicated staff assistance for ADLs. The plan of care for R72 dated 3/20/17, read, "Oral Care/Hygiene Provide set up for oral	F 282	The facility provided education on oral care, nail care, and turning and repositioning starting on 9/27/2017 and will continue until all are completed. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week for 4 weeks, and 1/week for 4 weeks. 3 residents/week will be audited for repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that nail/oral care and repositioning is provided to residents per facility policy and standards of practice. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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F 282	Continued From page 6	F 282		

hygiene BID (twice a day) in the AM and at HS (bedtime). Dressing/Personal hygiene/Bathing: Resident needs assist with dressing and grooming due to osteoarthritis and carpal tunnel. Staff to trim Residen't finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths,, the previous 6 weeks verified nail care was not performed for R72

During an observation on 9/19/17, at 9:58 a.m. R72 had fingernails that extended beyond the fingertips greater than 1/4th inch and appeared dirty with dark tan and brown substances accumulated under each nail. Furthermore, R72 had a heavy film of tan yellow substance on the upper teeth which R72 indicated was from not being offered assistance to brush teeth every day. R72 had own top teeth but no bottom teeth.

During an observation on 9/20/17, from 7:00 a.m. until 12:00 p.m., R72 was not offered nail care or oral care. R72 stated, "I cannot take care of myself because of the carpal tunnel in both hands, it is just too painful." Furthermore, R72 expressed frustration that the staff do not offer nail care and especially expressed a desire for oral care which the staff have not offered for weeks.

Document review of the facility policy titled, Oral Care and Nail Care, dated 11/9/07, read, "To assure adequate hygiene and grooming measures".

When interviewed on 9/20/17, at 2:00 p.m. nursing assistant (NA)-C verified oral care and nail care had not been performed for R72.

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F 282	Continued From page 7 When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing (IDON) verified the facility expectation for grooming would include nail care every week with bathing and whenever necessary. Oral care would be expected twice a day for all resident's. R59 did not receive a position change for 4 hours and 15 minutes. R59 was assessed as at risk for skin breakdown with a stage 2 pressure ulcer on the right gluteal cleft according to the plan of care, dated 8/30/17. Interventions include assist of 1-2 staff to reposition Q2H (every 2 hours) and prn (whenever necessary), total assist of 2 with Hoyer (mechanical lift) for transfers, resident does not ambulate. Document review of the facility policy titled, Repositioning, dated May 2013, directed to review the resident's care plan to evaluate for any special needs of the resident. When interviewed on 9/20/17, at 2:30 p.m. nursing assistant (NA)-A, NA-B & NA-C, who were working together,verified repositioning Q2H had not been performed for R72 since getting up into the wheel chair at 10:13 a.m. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing verified the facility expectation for residents assessed with skin breakdown would be to reposition every 2 hours according to the assessment and the plan of care.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		11/1/17

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F 309	Continued From page 8 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not complete a physician order of daily	F 309	Resident #98 is being weighed daily per MD orders.	

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F 309	Continued From page 9 weights for a resident receiving dialysis for 1 of 1 resident (R98) reviewed for dialysis. Findings include: Record review for R98 revealed a physicians's order, dated 5/26/17, for dialysis Tuesdays, Thursdays, Saturdays. The Order Summary Report also contained a physician's order, dated 6/29/17, that read, "Weight daily before breakfast..." A Weights and Vitals Summary form for R98 from 7/20/17 to 9/21/17 showed only 16 weights recorded. When interviewed on 9/21/17 at 1:47 p.m., licensed practical nurse (LPN)-C stated that it was the responsibility of the nursing assistants to obtain and record the daily weights. She explained that she has noticed in the recent past that the daily weights were not all in the electronic record of R98, and when she reminded the nursing assistants to complete the daily weights they told her that they were doing the daily weights and recording them in the electronic record, and they questioned if there was something wrong with the electronic record software. The interim director of nursing was interviewed about the missing weights on 9/21/17 at 2 p.m. and she replied that she was not aware of any malfunction of the electronic record software or the weight scales in the facility.	F 309	A list of all residents in the facility requiring daily weights was obtained and reviewed. These individuals are having their weights obtained daily per orders. Nursing staff were educated on obtaining daily weights starting on 9/27/2017 and will be ongoing until completion. The facility reviewed the system for obtaining daily weights. Residents with daily weights will be audited daily for 1 month. The DON is responsible for ensuring that daily weights are obtained per MD orders. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		11/1/17

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F 312	Continued From page 10 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal hygiene care for 2 of 3 residents (R59 & R72) in the sample who were dependent upon staff for personal cares. Findings include: R59 was assessed to require staff assistance with nail care and did not receive assistance in accordance with the plan of care interventions. During an observation on 9/19/17, at 9:11 a.m. R59 had fingernails that extended beyond the finger tips greater than 1/4th inch and appeared dirty with dark tan and brown substance accumulated under each nail. Two of the 10 fingernails had broken side, jagged edges. When interviewed on 9/19/17, at 9:11 a.m. R59 expressed the fingernails are too long and staff had not offered to clean or trim the fingernails. Furthermore, R59 indicated the substance under the nails was from "food" and feeding self without soaking or cleaning the fingernails for "many weeks." During an observation on 9/20/17, at 12:00 p.m. R59 continued to have unclean fingernails and two broken, jagged nails remained present. Document review of R59's Minimum Data Set (MDS) dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 required staff assistance for	F 312	Residents number 59 and 72 receive nail care per the facility policy and standards of care. All residents requiring assistance with nail care will are provided these services in accordance with facility standards. The facility provided education on nail care beginning on 9/27/2017 and will be ongoing until completion. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that nail care is provided to residents per facility policy and standards of practice. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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F 312	Continued From page 11	F 312		

activities of daily living (ADLs). The plan of care for R59 dated 1/1/17, read, "Staff to trim resident's finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R59.

R72 was assessed to require staff assistance with nail care and oral care and did not receive assistance in accordance with the plan of care interventions.

During an observation on 9/19/17, at 9:58 a.m. R72 had fingernails that extended beyond the fingertips greater than 1/4th inch and appeared dirty with dark tan and brown substances accumulated under each nail. Furthermore, R72 had a heavy film of tan yellow substance on the upper teeth which R72 indicated was from not being offered assistance to brush teeth every day. R72 had own top teeth but no bottom teeth.

During an observation on 9/20/17, from 7:00 a.m. until 12:00 p.m. R72 was not offered nail care or oral care. R72 stated, "I cannot take care of myself because of the carpal tunnel in both hands, it is just too painful." Furthermore, R72 expressed frustration that the staff do not offer nail care and especially expressed a desire for oral care which the staff have not offered for weeks.

Document review of R72's MDS dated 8/25/17, indicated the resident was cognitively intact and the CAA indicated staff assistance for ADL's. The plan of care for R72 dated 3/20/17, read, "Oral Care/Hygiene Provide set up for oral hygiene BID (twice a day) in the AM and at HS (bedtime).

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F 312	Continued From page 12 Dressing/Personal hygiene/Bathing: Resident needs assist with dressing and grooming due to osteoarthritis and carpal tunnel. Staff to trim Residen't finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R72 Document review of the facility policy titled, Oral Care and Nail Care, dated 11/9/07, read, "To assure adequate hygiene and grooming measures." When interviewed on 9/20/17, at 2:00 p.m. nursing assistant (NA)-C verified oral care and nail care had not been performed for R72. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing verified the facility expectation for grooming would include nail care every week with bathing and whenever necessary. Oral care would be expected twice a day for all residents.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		11/1/17

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F 314	Continued From page 13 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received timely repositioning for 1 of 3 resident's (R59) in the sample identified at risk for pressure ulcers. Findings include: R59 did not receive an offer to position change for 4 hours and 15 minutes During an observation on 9/19/17, at 3:00 p.m. R59 was sitting up in the wheel chair in the bedroom. When interviewed on 9/19/17, at 3:00 p.m. regarding the frequency of position changes, R59 indicated it was not unusual to sit up in the wheel chair without any staff offers to change position in the afternoon. R59 was aware of an open area on buttocks but was unable to feel pressure and did not experience pain in the buttocks. Document review of R59's Minimum Data Set (MDS), dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 had an existing pressure ulcer. The document titled, Braden Scale for Predicting Pressure Sore Risk, dated 7/22/17, verified R59 was at risk for pressure ulcers.	F 314	Resident #59 is turned and repositioned q 2 hours per plan of care. Individuals requiring q 2 hour turning and repositioning were identified; they are repositioned per policy. Nursing staff were inserviced beginning on 9/27/2017, and ongoing, regarding turning and repositioning dependent residents. 3 residents/week will be audited for repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that residents are turned and repositioned per facility standards and standards of practice.	

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Document review of the plan of care dated 8/30/17, indicated R59 was assessed as at risk for skin breakdown with a stage 2 pressure ulcer on the right gluteal cleft. Interventions included assist of 1-2 staff to reposition Q2H (every 2 hours) and prn (whenever necessary), total assist of 2 with Hoyer for transfers, resident does not ambulate.

Document review of the physician order, dated 6/6/17, read resident should be up in chair 1-2 hours three times daily. resident should not be up in wheelchair longer than 2 hours at a time, reposition every 2 hours while in bed.

Document review of the facility policy titled, Repositioning, dated May 2013, directed to review the resident's care plan to evaluate for any special needs of the resident.

During continuous observation on 9/20/17, from 7:00 a.m. until 10:13 a.m., R59 remained in bed positioned partially on the right side. There were no offers to change position while in bed. At 10:13 a.m. R59 was transferred from bed using the mechanical lift and positioned in the wheel chair. At 11:00 a.m. R59 left the unit to accompany family who also resided at the facility, and go to lunch in another area of the facility. At 1:17 p.m. R59 returned to the bedroom with family members. At 2:30 p.m. R59 verified staff had not offered any position changes since getting out of bed at 10:13 a.m..

When interviewed on 9/20/17, at 2:30 p.m. nursing assistant (NA)-A, NA-B & NA-C who were working together,verified repositioning Q2H had not been offered or performed for R72 since getting up into the wheel chair at 10:13 a.m.

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F 314	Continued From page 15 When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing (IDON) verified the facility expectation for residents assessed with skin breakdown would be to reposition every 2 hours according to the assessment and the plan of care. If a resident refused repositioning to report to the nurse and to reapproach the resident.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		11/1/17

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F 323	Continued From page 16 by: Based on document review, interview, and observations, the facility failed to establish interventions to reduce risk of falls for 1 of 3 residents (R209) reviewed for accidents, who was identified upon admission as at risk for falls, and fell twice in the facility. Findings include: Review of the Pre-Admission Assessment Information form, dated 9/12/17, revealed R209 was being admitted on 9/12/17 with a right hip fracture, and was at risk for falls. R209's face sheet, dated 9/20/17, listed diagnoses including fracture of neck of right femur, and dementia. R209's undated preliminary care plan had a typed note at the top of the form that this preliminary care plan must be initiated "within 24 hours of admission." The document included a section for designating whether or not the resident was a "Fall Risk" by checking either "Yes" or "No," and underneath the boxes was written, "If yes, implement safety measures." The form contained more boxes to check if any of the following safety measures were in place: sensor, grab bars, floor mat, or other safety measure. There was a line next to "other" for staff to clarify any other safety measures in place for R209. Staff had not checked a box to indicate whether or not R209 was a fall risk, and did not document that any safety measures were in place for R209. The Kardex Report was a report for nursing assistants to know how to care for residents, and what type of assistance they needed. R209's Kardex Report, dated 9/12/17, included a category for special interventions, which noted	F 323	Resident number 209 is no longer a resident at the facility. The facility□'s policy and procedure regarding falls interventions was reviewed and revised where necessary. Falls interventions are identified on the plan of care for residents at risk for falls. Licensed staff were inserviced on implementing falls interventions beginning on 10/11/2017 and will be ongoing. The falls interventions will be audited for completion by nursing administration, and/or a charge nurse, 48 hours after admission. 5 careplans/week X4 weeks, 3 careplans/week X4 weeks, 1 careplan/week X4 weeks will be audited. The DON is responsible to ensure that falls interventions are developed and initiated. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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that R209 needed a gait belt (a belt worn around the resident's waist for staff to assist with balance while walking or transferring), and limited assistance of one staff person to walk. The report did not specifically indicate R209 was at risk of falling.

During interview on 9/19/17, at 11:54 a.m. registered nurse (RN)-B said R209 had fallen twice since admission. The first fall was one day after admission on 9/13/17, and the second on 9/17/17. RN-B described the resident as "very confused."

Review of a fall report dated 9/13/17, revealed at 12:25 a.m. R209 fell in the common area. The incident description described R209 standing up in her wheelchair and falling down onto the floor, hitting the left elbow and hip on the floor. No new interventions were noted in this report.

Review of a fall report dated 9/17/17, revealed R209 was found in the doorway of the bathroom in the resident's room. The incident description said R209 was found laying on the left side on the floor, and explained was coming back from the bathroom, and fell backwards. The fall progress note dated 9/17/17 revealed R209 was "educated on call light use." No other new interventions were noted on this report.

In an an occupational therapy summary of skilled services completed 9/18/17, regarding service date 9/15/17, the occupational therapist noted attending a care conference with family. The summary described educating R209 on hip precautions, but the patient was unable to recall the precautions discussed after five minutes. The summary also noted R209 was unable to locate

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F 323	Continued From page 18 the call light to ask for help with toileting. During observation on 9/20/17, at 7:33 a.m. the door to R209's room was open by a couple inches. Through the opening, R209 could be seen sitting on the edge of the bed. Around this time, RN-B was passing in the common area when asked by the surveyor whether R209 was alone in the room, or with a nursing assistant. RN-B knocked on R209's door. R209 replied, "I'm just getting dressed, give me ten more minutes." RN-B asked R209 if there was anyone in the room helping the resident get ready, and R209 replied, "Give me five more minutes." RN-B confirmed that there was nobody currently helping the resident. RN-B said R209 was trying to get dressed, but clarified that R209 needed help, and went to find a nursing assistant to help the resident. At 7:37 a.m. nursing assistant (NA)-D entered R209's room to help. R209 sat at the edge of the bed dressed in a shirt and underwear. NA-D and the resident discussed what clothes to wear that day, and NA-D assisted the resident in dressing. At 7:40 a.m. NA-D explained needing to help R209 put shoes on, and directed the resident to remain seated. NA-D asked whether R209 already went to the bathroom, and R209 replied, "Yes." At this time, R209 began to stand up from the edge of the bed without assistance. NA-D said, "[R209], no, [R209], sit down please! Thank you." R209 sat down on the bed again while NA-D put shoes on the resident, then helped transfer R209 to the wheel chair before bringing R209 to the bathroom sink to wash face and brush teeth. At 7:48 a.m. NA-D said explained that R209 had already taken self to the bathroom that morning without help, because NA-D observed a brief on the bathroom floor, and had to flush the toilet. NA-D also observed R209	F 323		

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was already wearing underwear when NA-D entered the room to help with cares, so NA-D thought R209 must have started getting ready independently that morning. NA-D said R209 was not supposed to walk unassisted, and thought that R209 had previous falls, and came into the facility for falls and dementia. When asked if R209 was able to use a call light, NA-D thought it depended on how urgent the need, explaining if R209 had an urgent need, the resident would probably not use the call light for help.

During interview on 9/20/17, at 11:47 a.m. R209's family member (FM)-F explained that R209 had fallen previously, and knew that staff did not want R209 getting up without help. FM-F thought that R209 would get up and go to the bathroom alone if the resident felt the need to void. FM-F wondered if the facility was short staffed, and worried R209 would get up independently if there was nobody around to help.

During an interview on 9/21/17, at 2:55 p.m. RN-B said staff were not aware of any new interventions after R209's falls, and explained how staff kept R209's call light in reach, reminded R209 to use the call light, and reoriented R209 to the resident's room, and identity of staff.

During interview on 9/21/17, at 3:00 p.m., when asked if R209 had fallen at the facility, NA-E said that R209 had never fallen during NA-E's shift, so NA-E didn't know for sure. NA-E was aware that R209 was at risk for falls, and needed help walking. NA-E explained that the resident was always wanting to get up out of bed, then lay back down again, and vice versa. Because of this, NA-E had to keep an eye on the resident and try to ensure the resident was comfortable either in

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F 323	Continued From page 20 bed, or in the common area, or R209 might try to transfer alone. During interview on 9/21/17, at 3:20 p.m. the assistant director of nursing said staff tried to keep R209 in the common area to keep an eye on the resident, and kept the call light near the resident in R209's room, but that she could not find fall interventions in writing. Review of the Fall Prevention/Reduction Program policy, dated 4/16, revealed all residents would be assessed upon admission to determine the risk for falls. If deemed necessary, the fall prevention/reduction program would be implemented and followed. The policy required, "It will be noted on the [nursing assistant] assignment sheets any resident at high risk for falls." The policy continued, "All falls will be reviewed by the interdisciplinary team. Resident falls will be monitored and appropriate actions taken to prevent repeat occurrences as recommended by the interdisciplinary team members and the recommendations/interventions will be documented in the evaluation of the post fall event.... The resident's care plan will be updated as needed to reflect interventions as appropriate."	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 325		11/1/17

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F 325	Continued From page 21 (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not complete a physician order of daily weights for a resident receiving dialysis and experiencing weight loss for 1 of 1 resident (R98) reviewed for dialysis. Findings include: Record review for R98 revealed a physicians's order, dated 5/26/17, for dialysis Tuesdays, Thursdays, Saturdays. The Order Summary Report also contained a physician's order, dated 6/29/17, that read, "Weight daily before breakfast..." A Weights and Vitals Summary form for R98 from 7/20/17 to 9/21/17 showed only 16 weights recorded. On 7/20/17 R98's weight was listed as 164 lbs. and 140 lbs. on 9/19/17. When interviewed on 9/21/17 at 1:47 p.m., licensed practical nurse (LPN)-A stated that it was the responsibility of the nursing assistants to obtain and record the daily weights. She explained that she has noticed in the recent past that the daily weights were not all in the electronic record of R98, and when she reminded the nursing assistants to complete the daily weights	F 325	Resident #98 is being weighed daily per MD orders. A list of all residents in the facility requiring daily weights was obtained and reviewed. These individuals are having their weights obtained daily per orders Nursing staff were educated on obtaining MD/NP ordered daily weights starting on 9/27/2017 and will be ongoing until completion. The facility reviewed the system for obtaining daily weights. Residents with daily weight orders will be audited daily for 1 month. The DON is responsible for ensuring that daily weights are obtained per MD orders. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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F 325	Continued From page 22 they told her that they were doing the daily weights and recording them in the electronic record, and they questioned if there was something wrong with the electronic record software. The interim director of nursing was interviewed about the missing weights on 9/21/17 at 2 p.m. and she replied that she was not aware of any malfunction of the electronic record software or the weight scales in the facility. When interviewed on 9/21/17 at 10:27 a.m., registered dietician (RD)-A stated that R98 was on nutritional high risk monitoring related to receiving dialysis. She was also aware that the resident has experienced weight loss in recent months and had been receiving a nutritional supplement and needed more assistance at meals. She explained that she noticed that the daily weights were not consistently in the resident's record and she had spoken with nursing staff about the inconsistency.	F 325		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		11/1/17

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F 329	Continued From page 23 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents did not receive excessive medication doses when 1 of 5 residents (R48) reviewed for unnecessary medications received excessive doses of acetaminophen (greater than 4,000 milligrams) in a 24 hour period, and failed to identify non-pharmacological interventions for the use of an antidepressant for sleep for 1 of 5 residents (R66) who was reviewed for unnecessary medication.	F 329	Resident number 48□s medication regimen was reviewed for total mg of Acetaminophen potential per day. The MD/NP was updated and orders changed to ensure that if resident took all allowable PRN doses, that she would not exceed 4 grams of Acetaminophen. Resident #66 has a sleep careplan with nonpharmacological interventions identified. All resident□s medication has been	

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F 329	Continued From page 24 Findings include: Review of the admission record revealed R48 admitted to the facility on 8/19/17. Since admission, providers prescribed R48 various medication orders for acetaminophen (common brand name: Tylenol), both at scheduled times and as needed for pain. According to the United States Food and Drug Administration (FDA) website, "Acetaminophen can cause serious liver damage if more than directed is used." The current standard of practice for adults is not to exceed 4,000 milligrams (mg) of acetaminophen in a 24 hour period. Review of the medication administration record revealed R48 received greater than 4,000 mg of acetaminophen on the following days since admission to the facility: -8/24/17: received 4,950 mg -8/26/17: received 4,450 mg -8/27/17: received 4,600 mg -9/10/17: received 4,100 mg -9/19/17: received 4,100 mg Review of acetaminophen orders since admission revealed the following history of provider orders: -Acetaminophen Tablet 500 mg: give 1000 mg by mouth at bedtime for pain. Started 8/24/17 at 1900. Discontinued 8/24/17 at 2104. -Acetaminophen Tablet 500 mg: give 1000 mg by mouth one time a day for pain. Started 8/26/17 at 2000. Discontinued 8/29/17 at 1237. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give one tablet by mouth one time a day for pain for 7 days. started 8/29/17 at 2100. Completed 9/4/17.	F 329	reviewed for Acetaminophen amounts to ensure they do not exceed 4 grams/day. Residents taking a medication for sleep have a sleep careplan with nonpharmacological interventions. The nursing staff were inserviced on Acetaminophen dosing regulations and sleep careplans with nonpharmacological interventions beginning on 10/11/2017 and ongoing until completed. The consultant pharmacist reviews medications regimens monthly to audit for Acetaminophen dosing, his/her findings will be sent to the DON for order changes. Random new admission audits will be completed for Acetaminophen dosing and nonpharmacological interventions: 3 residents/week for 4 weeks, 2 residents/week for 4 weeks, and 1 resident/week for 1 week. The DON is responsible for ensuring that the Pharmacist recommendations are acted upon and that sleep careplans are developed with inclusion of nonpharmacological interventions are included. The Pharmacist will review her audit reports at QAPI with the Team for areas of improvement. Results of the audits will be forwarded to the facility□s QAPI meeting for input/suggestions.	

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F 329	Continued From page 25 -Acetaminophen Tablet 500 mg: Give 500 mg by mouth three times a day for osteoarthritis. Maximum (Max) Acetaminophen dose: 3000 mg/24 hours. Started 8/25/17 at 0800. Discontinued 8/29/17 at 1237. -Acetaminophen Tablet 500 mg: give 500 mg by mouth three times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/29/17 at 1800. Discontinued 9/21/17 at 1406. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/19/17 at 1700. Discontinued 8/24/17 at 1211. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/24/17 at 1700. Discontinued 8/24/17 at 2104. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/19/17 at 1530. Discontinued 8/29/17 at 1236. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg /24 hours. Started 8/29/17 at 1530. Discontinued 8/29/17 at 1630. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/29/17 at 1630. Calculating the total prescribed acetaminophen in the orders above revealed R48 had the potential to receive greater than 4,000 mg acetaminophen on many days if the medication was given as	F 329		

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scheduled, and if R48 had requested all available "as needed" orders. Listed below are dates when the total acetaminophen staff could have potentially given per provider order exceeded 4,000 mg:
-8/20/17-8/23/17: Potential of 4,600 mg
-8/24/17: Potential of 5,600 mg
-8/26/17-8/28/17: Potential of 5,100 mg
-8/29/17-9/4/17: Potential of 4,425 mg
-9/5/17-9/20/17: Potential of 4,100 mg

During interview on 9/21/17, at 1:08 p.m. registered nurse (RN)-C reviewed the medication administration record for September and verified that on 9/10/17 and 9/19/17, R48 received 4,100 mg of acetaminophen. RN-C confirmed the acetaminophen orders on those dates, and verified that giving the medication as ordered meant that R48 received greater than 4,000 total mg acetaminophen in one day. RN-C confirmed R48 had conflicting maximum acetaminophen limits within the medication orders, and was asked whether R48 should have no more than 3,000 mg or 4,000 mg acetaminophen daily. RN-C followed up with the provider, and confirmed at 1:52 p.m. that R48's maximum daily limit was supposed to be 4,000 mg of acetaminophen.

During interview on 9/22/17, at 9:38 a.m. the administrator calculated the total acetaminophen given by staff on 8/27/17, and confirmed R48 received 4,600 mg acetaminophen, based on the medication administration record. The administrator said the facility did not have a specific policy written about daily acetaminophen limits, but that they were to follow the standard limit of no more than 4,000 mg of acetaminophen daily.

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F 329	Continued From page 27 R66 's current physician orders indicated the resident had a diagnosis of insomnia, and was prescribed Trazodone HCl 25 mg orally at bedtime for insomnia. The quarterly minimum data set (MDS) dated 7/6/17 indicated the resident had diagnoses of dementia and psychotic disorder. The MDS indicated R66 was taking antipsychotic and antidepressant medications. A review of the electronic current care plan was completed on 9/20/17. The care plan did not reflect any identification of a problem with insomnia and did not identify any nonpharmacological interventions for insomnia. On 9/21/17 at 1:15 p.m. the interim director of nursing reviewed the care plan and verified insomnia was not included in the care plan and did not identify nonpharmacological interventions for insomnia.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		11/1/17

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F 371	Continued From page 28 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare and serve food in a manner that ensured food safety, and failed to wash dishes at temperatures appropriate for sanitization. This had the potential to affect 37 of 53 residents (residents living on Evergreen and Hawthorn units) in the facility at the time of survey. Findings include: During a dining observation on 9/18/17, at 5:13 p.m. 13 residents ate in the Evergreen dining room. Food server (FS)-A was observed serving the residents in the dining room, and also dishing up room trays for residents who ate in their rooms. FS-A wore a hairnet that had slipped up and off the head, and loosely sat around long hair that was secured into a bun at the crown of the head. The slipping hairnet left exposed hairs at the nape of the neck. At 5:19 p.m. FS-A came out of the kitchenette with a plate of food in each hand, and hair coming out of the front of the	F 371	DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their hair adequately, they wash their hands and utilize gloves per policy/standards, thermometers are disinfected properly between foods, chemical sanitzer is used in the dish machines and its□ tested daily. Dining staff were inserviced beginning 9/27/2017 and will be ongoing until completed on: hairnet usage, hand washing standards, glove use, disinfecting thermometer probes, infection control basics, chemical testing for dish machines, and safe food handling to minimize risk of foodborne illnesses. 3 audits/week X4 weeks, 2 audits/week X4 weeks, 1 audit/week X4 weeks will be completed on hairnet compliance, hand washing, dish machine chemical testing,	

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F 371	Continued From page 29 hairnet by the face. FS-A was not wearing gloves, set the plates in front of residents, swiped hair away from the face with bare fingers, and went back into the kitchenette to dish up and bring out two more plates of food without performing hand hygiene. After dropping off the plates, FS-A returned to the kitchenette and prepped more plates of food, used the microwave, and pulled silverware from the drawers. A sign on the door to the kitchenette said in all capital letters, "HAIR RESTRAINTS MUST BE WORN IN THIS AREA!" At 5:30 p.m. the dining services director (DSD) entered the kitchenette and asked FS-A about not wearing gloves. The DSD told FS-A to fix the hairnet that was falling off. FS-A was heard asking, "Is it falling off again?" After fixing the hairnet, The DSD reminded FS-A to wash hands after tucking stray pieces of hair back in the hairnet. FS-A turned on the water and washed hands. At 5:51 FS-A entered the dining room with gloves on, and collected dirty cloth napkins from tables to be cleaned. FS-A returned to the kitchenette with the gloves on, picked up some creamer packets with the same gloved hands, and then served up more food on a plate without changing gloves or performing hand hygiene. In an interview on 9/18/17, at 5:55 p.m. FS-A confirmed the hairnet was sliding off during dining service, and explained not realizing it until the DSD mentioned it. When asked about the policy for glove use, FS-A said the previous dietary services director told staff they did not have to wear gloves if they did not have any contact with food. Now there was a newer DSD, and FS-A was not sure if the rules about glove use had changed. In a follow-up interview at 6:04 p.m. the DSD, expected staff to wash and dry hands before wearing gloves, and then change gloves	F 371	glove use, and general infection control issue. follow up. Results of the audits will be reviewed at QAPI. The Dining Services Manager is responsible for compliance.	

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after touching the face, hair, or other non-food surfaces. The DSD expected staff to wash and dry hands between glove changes, and to cover all hair in a hairnet.

Review of the Handwashing policy, dated 3/9/16, revealed the following examples, among others, when dining services staff were expected to wash hands: before serving food, after bussing dishes.

During observation of food preparation in the kitchen on 9/21/17, at 11:10 a.m. Cook (C)-A placed thawed, raw meat patties inside of a chilled drawer that was underneath the grill. C-A said they were to be cooked later. C-A inserted a probe thermometer inside the raw meat patties to ensure they were below 40 degrees Fahrenheit (F). Between checking temperatures of different pieces of raw meat, C-A quickly wiped the probe of the thermometer one time on a wet towel. After checking the temperature of the raw meat, C-A again quickly wiped the probe one time on the wet towel, then immediately proceeded to use the same probe thermometer to check the temperature of ready to eat foods on the chilled salad cart, such as chicken salad, egg salad, mayonnaise, onion, tomato, and other fresh, ready to eat vegetables. Between taking the temperature of each food item, C-A wiped the probe one time on the wet towel. When asked about using the same thermometer from the raw meat to the ready to eat foods, C-A explained that the towel was soaked in Multi-Quat Sanitizer solution.

During interview on 9/21/17, at 11:27 a.m., the dining services director (DSD) was not sure if it was okay for the same thermometer probe to be used on raw meat, wiped with the Multi-Quat

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Sanitizer, and then immediately used on ready to eat foods, but wanted to call and ask the representative from the company that manufactured the Multi-Quat Sanitizer. C-A explained being trained that it was okay to use the same thermometer on raw meat, and then ready to eat foods, as long as it was wiped with a Multi-Quat Sanitizer soaked towel. At 11:35 a.m. The manufacturer representative spoke to the DSD over the phone, and clarified that a Multi-Quat Sanitizer saturated towel disinfected food contact surfaces after approximately one minute. At 11:41 a.m. the DSD told dining staff to pull all the food off the chilled salad cart before serving residents, and replace it with fresh food, just in case there had been contamination from the temperature probe.

Review of a manufacturer information sheet about Multi-Quat Sanitizer revealed the following directions for use: "Apply Oasis 146 Multi-Quat Sanitizer at proper use solution. Expose all surfaces of equipment, ware or utensils to the sanitizing solution for a period of not less than one minute. Air dry."

During the initial kitchen tour on 9/18/17, at 12:28 p.m. the dietary services director (DSD) explained the EC-44 Dishmachine used high temperatures to clean. High temperature machines sanitize dishes using hot water, rather than chemicals.

During observation of the EC-44 Dishmachine on 9/21/17, at 11:56 a.m. the dishwasher (D)-E said the water temperatures would get low. D-E said the dishmachine had been like this for a while, and explained after the machine ran for a long time throughout the day, the temperatures dropped. D-E said the wash temperature drops

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first, and then the rinse temperature "goes next." D-E said the previous night, temperatures dropped until the wash temperature was around 140 degrees Fahrenheit (F), and the final rinse temperature dropped below 170 degrees F. D-E logged water temperatures on a Dishwasher Temperature Log, and the September 2017 log showed temperatures were frequently lower than required. On 9/13/17, the wash and rinse temperatures dropped as low as 135 degrees F and 165 degrees F, respectively. Type on the bottom of the Dishwasher Temperature Log required, "Wash temperature must reach 150 [degrees F]" and "Rinse temperature must reach 180 [degrees F]".

Review of the EC-44 Dish machine manufacturer information sheet revealed the following machine specifications for high temperature sanitization: Wash temperature: 160 degrees F. Sanitizing rinse: 180 degrees F.

The DSD explained being previously unaware of the temperature problems, and called the manufacturer on 9/21/17 at 12:04 p.m. to request that they visit the facility and look at the dish machine.

During an interview on 9/21/17, at 2:15 p.m. the administrator clarified that the EC-44 Dish machine in the kitchen washed all the dishes for the Evergreen and Hawthorn units, but that the Rosewood unit had its own dishwasher. The administrator explained that the EC-44 Dish machine used a temperature booster to boost the temperature up to 70 degrees higher. The administrator described how the hot water temperature in the facility was capped at 115 degrees F to prevent burns. Consequently, if the

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F 371	Continued From page 33 water temperature cooled more than 5 degrees before reaching the kitchen dish machine, then the booster was not able to boost the temperature to 180 degrees F, resulting in water temperatures that were too cool. Because of the risk of low temperatures, the administrator said kitchen staff had just implemented a chemical that day to be used in the dish machine, which would sanitize the dishes at lower water temperatures. Additionally, the facility had not implemented a comprehensive infection control program to include consistent tracking, trending, and analysis of illnesses in the facility, including but not limited to foodborne illness, and other gastrointestinal illness, that could potentially result from food contamination, poor hand hygiene, and improper dishwashing. See F441.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities	F 428		11/1/17

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F 428	Continued From page 34 to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the pharmacist failed to identify and report irregularities to the attending physician, facility medical director, and director of nursing, when 1 of 5 residents (R48) reviewed for unnecessary medications received excessive doses of	F 428	Resident number 48□s medication regimen was reviewed for total mg of Acetaminophen potential per day. The MD/NP was updated and orders changed to ensure that if resident took all allowable PRN doses, that she would not exceed 4	

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F 428	Continued From page 35 acetaminophen (greater than 4,000 milligrams) in a 24 hour period. Findings include: Review of the admission record revealed R48 admitted to the facility on 8/19/17. Since admission, providers prescribed R48 various medication orders for acetaminophen (common brand name: Tylenol), both at scheduled times and as needed for pain. According to the United States Food and Drug Administration (FDA) website, "Acetaminophen can cause serious liver damage if more than directed is used." The current standard of practice for adults is not to exceed 4,000 milligrams (mg) of acetaminophen in a 24 hour period. Review of the Consultant Pharmacist Communication to Physician form revealed that the pharmacist reviewed R48's medication regimen on 9/7/17. The pharmacist did not note excessive acetaminophen doses given to R48, or potential for excessive acetaminophen doses on the communication form. Review of the medication administration record revealed R48 received greater than 4,000 mg of acetaminophen on the following days prior to the pharmacist's visit on 9/7/17: -8/24/17: received 4,950 mg -8/26/17: received 4,450 mg -8/27/17: received 4,600 mg Review of acetaminophen orders since admission revealed the following history of provider orders: -Acetaminophen Tablet 500 mg: give 1000 mg by	F 428	grams of Acetaminophen. All resident□s medication regimen has been reviewed by the consultant pharmacist for Acetaminophen amounts to ensure they do not exceed 4 grams/day. The nursing staff were inserviced on Acetaminophen dosing regulations beginning on 10/11/2017 and ongoing until completed. The consultant pharmacist reviews medications regimens monthly to audit for Acetaminophen dosing, his/her findings will be sent to the DON for order changes. Random new admission audits will be completed for Acetaminophen dosing: 3 residents/week for 4 weeks, 2 residents/week for 4 weeks, and 1 resident/week for 1 week. The consultant pharmacist is responsible for completing a medication regimen review monthly for each resident. The Pharmacist will review her audit reports at QAPI with the Team for areas of improvement. Results of the audits will be forwarded to the facility□s QAPI meeting for input/suggestions.	

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F 428	Continued From page 36 mouth at bedtime for pain. Started 8/24/17 at 1900. Discontinued 8/24/17 at 2104. -Acetaminophen Tablet 500 mg: give 1000 mg by mouth one time a day for pain. Started 8/26/17 at 2000. Discontinued 8/29/17 at 1237. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give one tablet by mouth one time a day for pain for 7 days. started 8/29/17 at 2100. Completed 9/4/17. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth three times a day for osteoarthritis. Maximum (Max) Acetaminophen dose: 3000 mg/24 hours. Started 8/25/17 at 0800. Discontinued 8/29/17 at 1237. -Acetaminophen Tablet 500 mg: give 500 mg by mouth three times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/29/17 at 1800. Discontinued 9/21/17 at 1406. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/19/17 at 1700. Discontinued 8/24/17 at 1211. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/24/17 at 1700. Discontinued 8/24/17 at 2104. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/19/17 at 1530. Discontinued 8/29/17 at 1236. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg /24 hours. Started 8/29/17 at 1530. Discontinued 8/29/17 at 1630.	F 428		

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F 428	Continued From page 37 -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/29/17 at 1630. Calculating the total prescribed acetaminophen in the orders above revealed R48 had the potential to receive greater than 4,000 mg acetaminophen on many days if the medication was given as scheduled, and if R48 had requested all available "as needed" orders. Listed below are dates prior to the pharmacist's visit on 9/7/17, when the total acetaminophen staff could have potentially given per provider order exceeded 4,000 mg: -8/20/17-8/23/17: Potential of 4,600 mg -8/24/17: Potential of 5,600 mg -8/26/17-8/28/17: Potential of 5,100 mg -8/29/17-9/4/17: Potential of 4,425 mg -9/5/17-9/7/17: Potential of 4,100 mg Additionally, at the time of the pharmacist's medication regimen review on 9/7/17, there were conflicting maximum daily acetaminophen limits, as can be seen in the order list above. One order listed a maximum of 3,000 mg/24 hours, and another listed 4,000 mg/24 hours. During interview on 9/21/17, at 3:57 p.m. the pharmacist confirmed visiting the facility once a month to review medications, and said medication limits were part of that review. The pharmacist reviewed R48's record, and saw an order with a 4,000 mg daily limit for acetaminophen. The pharmacist said the expectation was for staff to follow the order and give no more than 4,000 mg per day. During interview on 9/22/17, at 9:38 a.m. the administrator said the facility did not have a	F 428		

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F 428	Continued From page 38 specific policy written about daily acetaminophen limits, but that they were to follow the standard limit of no more than 4,000 mg of acetaminophen daily.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		11/1/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

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F 441	Continued From page 39 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had the potential to affect all 53 residents,	F 441	Resident #59 has a new catheter system in place. Residents with a catheter have the new bag-system in place. Glucometers are disinfected after each use. The facility	

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F 441	Continued From page 40 staff and visitors in the facility. The facility also failed to use infection control measures during a dressing change for one of one resident (R7) observed during a dressing change. In addition, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring and hand hygiene for 6 of 6 residents (R77, R90, R93, R202, R205, R210), observed, who required blood glucose monitoring, and failed to properly sanitize 1 of 1 resident's (R59) urinary catheter drainage bag and tubing. Findings include: During a random interview on 9/20/17 at approximately 1:00 p.m. the administrator reported there were no up to date infection control logs that would include ongoing tracking and trending of resident infections. On 9/21/17 at 12:30 p.m. the interim director of nursing (IDON) reported the system for infection control monitoring had not been kept up since after March 2017. The IDON had contacted the previous staff person for additional information and was unable to obtain such information. For the months of January, February and March names of residents, room numbers, diagnoses and treatment were identified in the three month documentation, however, there was no analysis completed. The IDON was unaware of how data was collected from various units and indicated that going forward, would include information from the pharmacy as well as laboratory reports. The surveillance logs did not identify if residents were admitted with infections or if the infections were acquired at the facility. There was no identification of the organism and no identification	F 441	has implemented an infection control prevention and control program that includes the required elements of identifying, implementing, monitoring, and reporting of infections. Infection Control logs are kept per facility policy and regulations. Staff have been re-educated beginning on 9/27/2017 on handwashing, glucometer disinfecting, glove use, as well as other infection control basics/polices. Infection control rounds/audits will be completed 3X□s/week by the Infection Control Preventionist, or her qualified designee, to ensure infection control practices are being adhered to in the facility. The outcome of these audits will be reviewed monthly at the IC meeting for trends and tracking. The implemented IC log will also be reviewed monthly by the Team. Issues identified with IC practices, including catheter cleaning, will be reviewed by the QAPI Team quarterly for their input/suggestions. The Infection Control Preventionist is responsible for ensuring that the facility has a comprehensive IC program in place at the facility.	

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F 441	Continued From page 41	F 441		

of resolution dates of the illness. Documentation lacked specific infections, organisims, whether community based or house acquired. The IDON confirmed that no further monitoring of patient infections had occurred since March 2017.

When asked when infection control was discussed at the facility's quality assurance (QA) meeting, on 9/22/17 at approximately 11:00 a.m., the administrator indicated infection control was to be discussed quarterly, but will be changed to monthly review in the future.

An infection control policy was requested, however not provided.

On 9/20/17 at 1:30 p.m. a random observation of a dressing change, for an excoriated area, for R7 was made. The registered nurse (RN)-A entered the room, washed hands and applied gloves. Two nursing assistants were assisting with holding R7 on the right side exposing the buttocks and sacral area. The old dressing had been removed and the area appeared excoriated and red. RN-A sprayed a cleansing spray onto a 4 x 4 inch gauze square and cleansed the area, tossed the gauze onto a wrapper paper and again sprayed the cleansing spray onto another 4 x 4 gauze square and cleansed the area of the excoriated buttocks. The area was approximately 6 cm x 4 cm across the upper half of both buttocks. RN-A used a pen from the pocket of uniform and dated the dressing. RN-A placed paper and dressing papers on top of an opened dressing envelope. RN-A donned another pair of gloves, without washing hands or using alcohol solution, and proceeded to press a dressing over the

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F 441	Continued From page 42 excoriated area on the sacral and buttocks area. When finished, RN-A picked up the remaining dressing debris and disposed of it in the trash. RN-A removed gloves and then used hand sanitizer gel that was clipped to uniform. RN-A left the room. When interviewed regarding the procedure, RN-A acknowledged she had forgotten to wash hands after removing the soiled gloves. On 9/21/17 at 12:25 p.m. the Interim director of nursing was asked about glove changes and verified the registered nurse should have washed hands after cleansing the area and before putting on clean gloves. During an observation on 9/18/17, at 4:13 p.m. of blood glucose monitoring, licensed practical nurse (LPN)-B entered R202's bedroom carrying the container of glucometer supplies. LPN-B set the container on the tray table and without washing/sanitizing hands donned a pair of gloves, obtained R202's blood, set the contaminated glucometer in with the clean supplies, removed gloves, left the room and while walking down the hallway, retrieved a ringing phone from the uniform pocket, answered the phone, and then set the phone back at the nurses station. LPN-B then sanitized the glucometer machine for 10 seconds with a wipe. LPN-B did not wash/sanitize hands. During an observation on 9/18/17, at 4:36 p.m. LPN-B took the glucometer container to R210 and set the container with the glucometer supplies on R210's personal arm chair in the	F 441		

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bedroom. LPN-B obtained gloves from the bathroom without washing/sanitizing hands and obtained blood from R210. LPN-B removed gloves and washed hands with running water for 6 seconds. LPN-B put the contaminated glucometer into the container, left the room and sanitized the glucometer at the med cart using the wipe for 15 seconds, then returned the glucometer to the container.

During an observation on 9/18/17, at 4:29 p.m. LPN-B took the container with glucometer supplies to R205, set the container on the counter, retrieved the glucometer, no hand hygiene and donned gloves to obtain the blood glucose reading. LPN-B set the contaminated glucometer in the container, removed gloves, did not wash/sanitize hands, and proceeded back to the med cart and sanitized the glucometer with a wipe for 15 seconds and put the glucometer back into the container. LPN-B then sanitized hands with alcohol gel.

When interviewed on 9/18/17, at 4:45 p.m. LPN-B was not sure how many seconds the glucometer was to be sanitized with the wipe and was not aware of the time spent but stated, "For a while."

During an observation on 9/20/17, at 7:05 a.m. trained medication aide (TMA-A) took the glucometer container and supplies to R77's bedroom, and set the container on the tray table. TMA-A donned gloves without washing/sanitizing hands, obtained the blood test and without sanitizing the glucometer machine put it back in the container with the clean supplies. TMA-A removed gloves and left the room. TMA-A did not wash/sanitize hands or the glucometer machine.

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F 441	Continued From page 44 During an observation on 9/20/17, at 7:15 a.m., TMA-A took the glucometer container supplies into R93, set the glucometer container on the tray table, donned gloves from the bathroom supply, obtained blood from R93 and without sanitizing the machine, put it back in the container. removed gloves and left the room without washing/sanitizing hands or glucometer. During an observation on 9/20/17, at 7:30 a.m. TMA-A entered the room of R90, set the glucometer container on the tray table and at the sink washed the palms of hands for 7 seconds, donned gloves taken from uniform pocket, After obtaining blood from R90, TMA-A put the contaminated glucometer back into the container, took a pen out of the uniform pocket and wrote down the glucometer number, then removed contaminated gloves, retrieved the glucometer container and took the supplies back to the med cart. TMA-A documented the blood sugar in the computer using the computer mouse to navigate the documentation. Then, TMA-A sanitized hands with alcohol gel . There was no cleaning of the glucometer. When interviewed on 9/20/17, at 11:59 a.m. TMA-A verified not sanitizing the glucometer in-between resident use because did not know they were supposed to sanitize the machine in-between uses. TMA-A did not know what product was to be used to sanitize the glucometer and did not know there was a required period of time for the sanitizing depending on the wipe used and manufacturer recommendations. Document review of the facility policy, titled; Glucometer:Cleaning and Care, dated August 2012, directed Glucometers will be cleaned after	F 441		

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each use and cared for properly. To ensure consistency in testing and results and prevent the spread of infection and infectious diseases. The cleaning procedure Disinfect meter with germicidal disposable wipes and follow manufacturer's guidelines for dry time,

Document review of the facility Safety Data Sheet dated January 5, 2015 indicated moistened disinfecting bleach wipes of 1:10 concentration of sodium hypochlorite (bleach). required a 2 minute saturation time on the glucometer and then allow to air dry.

Document review of the facility policy titled; Handwashing, dated March 9, 2016, directed staff to apply soap over the entire hands and wrists and to rub hands vigorously together for at least 20 seconds. Furthermore, the policy directed Hand Sanitizer (Not a replacement for hand washing. Use only after washing hands) and spread over complete surface of hands (front and back) and Rub until dry.

Document review of the policy titled; Disposable glove use, dated June 1, 2017, directed staff to wash hands immediately after glove removal.

When interviewed on 9/20/17, at 12:30 p.m. the interim director of nursing (IDON) verified staff are to wash hands before and after removing gloves, and the glucometers are to be disinfected with the bleach product for 2 minutes per manufacturer recommendations

R59's cares were observed on 9/20/17, at 10:00 a.m. Nursing assistant (NA)-B was in the R59's

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bathroom, tending to a foley catheter bag. NA-B poured 4 ounces of vinegar into the connection tubing of R59's foley catheter bag. Then, NA-B swished the vinegar in the foley bag and released the bottom valve and drained the vinegar into the toilet. NA-B then ran running water from the sink into the connection tubing of the foley catheter bag and emptied that into the toilet. NA-B hung the foley catheter bag on the shower hand rail and there was no cap on the end of the tubing.

Document review of an undated policy titled; Urinary Catheter Daily Cares and Bag Change Skills Competency Checklist, read; a. Clean the bag with soapy water, b. Rinse the bag well with clean tap water, c. Soak the bag for 30 minutes in a solution of one part vinegar to three parts water, d. Empty the bag, e. Air dry the bag, f. If available, put a cap that has been disinfected with alcohol on the connecting tip, g. Replace tubes and catheter bags that are cracked, hardened, or difficult to see into.

When interviewed on 9/20/17, at 12:30 p.m., the IDON explained not being familair with how staff cleaned catheter bags/tubing, was not familiar with pouring undiluted vinegar into the catheter tubing, and would need to do some audits.

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K 000	INITIAL COMMENTS FIRE SAFETY 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St Theresa of Woodbury was not found in substantial 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Facility and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division	K 000		

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

Electronically Signed — 10/13/2017

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 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St Theresa of Woodbury is a 2-story building with a full basement that is not considered part of this survey. The original building was built in 2016 and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection in the corridors and areas open to the corridor that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms. Each floor is separated by one 1 hour smoke barrier and one 2 hour fire barrier. The facility has a capacity of 56 beds and a census of 48 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		10/25/17

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K 222	Continued From page 3 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the proper operation of exit door locking devices. NFPA 101, Life Safety Code, 2012 edition section 7.2.1.7. This deficient practice could cause the door not to open, affecting 18 of the 56 residents and an undetermined amount of staff and visitors. Findings include: At 11:30 am on 09/21/2017 observations revealed the delayed egress feature on the exit door of the first floor transitional wing was not operable. This deficient condition was confirmed by The	K 222	1. Twin Cities Hardware was called and they repaired the door on the Transitional Care unit to be operable. 2. Door was repaired 10/6/2017. 3. Plant Operations Director is responsible for operable doors.	

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	245632	A. BUILDING **01 - ST THERESE OF WOODURY** B. WING _____	**09/21/2017**

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ST THERESE OF WOODBURY LLC	**7555 BAILEY ROAD WOODBURY, MN 55129**

(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
K 222	Continued From page 4 Executive Director and the Plant Operations Director.	K 222		
K 293 SS=D	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to properly identify two exterior doors as required in The Life Safety Code NFPA 101 2012 edition section 7.10.8.3. This deficient condition could affect the exiting of an undetermined amount of residents, staff and visitors. Findings include: At 11:10 am on 09/21/2017 observations revealed the 2nd floor dining room doors leading to a closed patio were not signed with "No Exit". This deficient condition was confirmed by The Executive Director and the Plant Operations Director.	K 293	1. No Exit signs were placed on the 2 identified doors. 2. The work was completed on 9/25/2017 3. The Plant Operations Director is responsible for proper signage on the doors.	10/25/17
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341		10/25/17

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K 341	Continued From page 5 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents, staff and visitors. Findings include: At 10:37 am on 09/21/2017 observations revealed a smoke detector within 36 inches of an HVAC diffuser on the 2nd floor inside the kitchen in front of the coolers. This deficient condition was confirmed by The Executive Director and the Plant Operations Director.	K 341	1. The smoke detector in the identified area was moved to be more than 36 inches from the HVAC diffuser. 2. This was completed on 10/6/2017. 3. The Plant Operations Director is responsible for ensuring that smoke detectors are not within 36 inches of a diffuser.	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing	K 353		10/25/17

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K 353	Continued From page 6 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents staff and visitors. Findings include: At 10:35 am on 09/21/2017 observations revealed 2 sprinkler heads in the kitchen coolers that appeared to be defective due to lack of fluid color in the frangible bulbs. This deficient condition was confirmed by The	K 353	1. The sprinkler heads in the coolers were replaced with functional heads. 2. The work was completed on 10/6/2017. 3. The Plant Operations Director is responsible for ensuring functional sprinkler heads.	

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K 353	Continued From page 7 Executive Director and the Plant Operations Director.	K 353		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2017

Ms. Kay Emerson, Administrator
St. Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: State Nursing Home Licensing Orders - Project Number S5632001

Dear Ms. Emerson:

The above facility was surveyed on September 18, 2017 through September 22, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor, at susanne.reuss@state.mn.us or (651) 201-3793.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 18, 19, 20, 21, 22, 2017 surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop a preliminary care plan to include interventions to reduce risk of falls for 2 of 3 residents reviewed (R193, R209) for accidents, who were identified at admission as at risk for falls. Findings include: Review of the Pre-Admission Assessment Information form, dated 9/12/17, revealed R209 was being admitted on 9/12/17 with a right hip fracture, and was at risk for falls. R209's face sheet, dated 9/20/17, listed diagnoses including fracture of neck of right femur, and dementia. R209's undated preliminary care plan had a typed note at the top of the form that this preliminary	2 560	Resident number 209 is no longer a resident at the facility. The facility's policy and procedure regarding falls interventions was reviewed and revised where necessary. Falls interventions are identified on the plan of care for residents at risk for falls. Licensed staff were inserviced on implementing falls interventions beginning on 10/11/2017 and will be ongoing. The falls interventions will be audited for completion by nursing administration, and/or a charge nurse, 48 hours after admission. 5 careplans/week X4 weeks, 3 careplans/week X4 weeks, 1	11/1/17

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2 560	Continued From page 3 care plan must be initiated "within 24 hours of admission." The document included a section for designating whether or not the resident was a "Fall Risk" by checking either "Yes" or "No", and underneath the boxes was written, "If yes, implement safety measures." The form contained more boxes to check if any of the following safety measures were in place: sensor, grab bars, floor mat, or other safety measure. There was a line next to "other" for staff to clarify any other safety measures in place for R209. Staff had not checked a box to indicate whether or not R209 was a fall risk, and did not document that any safety measures were in place for R209. During interview on 9/19/17, at 11:54 a.m. registered nurse (RN)-B said R209 had fallen twice since admission. The first fall was one day after admission on 9/13/17, and the second on 9/17/17. RN-B described the resident as "very confused." During interview on 9/20/17, at 7:48 a.m. nursing assistant (NA)-D thought R209 fell previously, and came to the facility for falls and dementia. During an interview on 9/20/17, at 2:17 p.m. the administrator clarified that the preliminary care plan along with the Pre-Admission Assessment was considered to be the preliminary care plan. On 9/21/17, at 3:20 p.m. the assistant director of nursing said staff tried to keep R209 in the common area to keep an eye on the resident, and kept the call light near the resident in R209's room, but that she could not find fall interventions in writing. Review of the undated policy titled, Care Plans - Preliminary, revealed the following policy	2 560	careplan/week X4 weeks will be audited. The DON is responsible to ensure that falls interventions are developed and initiated. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 560	Continued From page 4 statement: "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission." R193 was admitted to the facility on 9/8/17 with diagnoses of history of falling and rhabdomyolysis. R193 had been admitted from a acute care hospital after an unwitnessed fall at home. A review of nursing progress notes, dated 9/8/17, indicated resident "had fallen in the past and she is on sedatives which puts her at risk for fall." A review of the Care Plan -Preliminary (initiated within 24 hours of admission) had a yes/no check off box for fall risk and neither was checked off. No safety measures were identified. On 9/20/17 at 1:04 p.m. the interim director of nursing verified the resident was a fall risk and that information should have been added to the initial care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review policies/procedures, train staff and monitor to assure that preliminary care plans are developed to include interventions to reduce risk of falls for residents that are admitted to the facility and identified at risk for falls. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		

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2 565	Continued From page 5	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 2 of 3 residents (R59 & R72) in the sample who required assistance with nail care, 1 of 3 residents (R72) who required assistance with oral care and 1 of 3 residents (R59) reviewed for pressure ulcers who required assistance with positioning. Findings include: R59 was assessed to require staff assistance with nail care and did not receive assistance in accordance with the plan of care interventions. Document review of R59's Minimum Data Set (MDS) dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 required staff assistance for activities of daily living (ADLs). The plan of care for R59 dated 1/1/17, read, "Staff to trim resident's finger and toe nails as needed following weekly bath". Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R59.	2 565	Residents number 59 and 72 receive nail care per the facility policy and standards of care. On 9/21/2017 all resident's nails were audited by the DON. Resident #72 receives oral care per facility policy and standards of care (in the AM, at HS, and PRN). Resident 59 is turned and repositioned per careplan. All residents requiring assistance with: oral care, nail care, and turning and repositioning will be provided these services in accordance with facility standards. The facility provided education on oral care, nail care, and turning and repositioning starting on 9/27/2017 and will continue until all are completed. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week for 4 weeks, and 1/week for 4 weeks. 3 residents/week will be audited for repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/week for 4 weeks. T he DON is responsible for ensuring that	11/1/17

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2 565	Continued From page 6 During an observation on 9/19/17, at 9:11 a.m. R59 had fingernails that extended beyond the finger tips greater than 1/4th inch and appeared dirty with dark tan and brown substance accumulated under each nail. Two of the 10 fingernails had broken side, jagged edges. When interviewed on 9/19/17, at 9:11 a.m. R59 expressed frustration that the fingernails are too long and staff had not offered to clean or trim the fingernails. Furthermore, R59 indicated the substance under the nails was from "food" and feeding self without soaking or cleaning the fingernails for "many weeks." R72 was assessed to require staff assistance with nail care and oral care and did not receive assistance in accordance with the plan of care interventions. Document review of R72's MDS (Minimum Data Set), dated 8/25/17, indicated cognitively intact and the CAA indicated staff assistance for ADLs. The plan of care for R72 dated 3/20/17, read, "Oral Care/Hygiene Provide set up for oral hygiene BID (twice a day) in the AM and at HS (bedtime). Dressing/Personal hygiene/Bathing: Resident needs assist with dressing and grooming due to osteoarthritis and carpal tunnel. Staff to trim Residen't finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths,, the previous 6 weeks verified nail care was not performed for R72 During an observation on 9/19/17, at 9:58 a.m. R72 had fingernails that extended beyond the fingertips greater than 1/4th inch and appeared dirty with dark tan and brown substances accumulated under each nail. Furthermore, R72	2 565	nail/oral care and repositioning is provided to residents per facility policy and standards of practice. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 565	Continued From page 7	2 565		

had a heavy film of tan yellow substance on the upper teeth which R72 indicated was from not being offered assistance to brush teeth every day. R72 had own top teeth but no bottom teeth.

During an observation on 9/20/17, from 7:00 a.m. until 12:00 p.m., R72 was not offered nail care or oral care. R72 stated, "I cannot take care of myself because of the carpal tunnel in both hands, it is just too painful." Furthermore, R72 expressed frustration that the staff do not offer nail care and especially expressed a desire for oral care which the staff have not offered for weeks.

Document review of the facility policy titled, Oral Care and Nail Care, dated 11/9/07, read, "To assure adequate hygiene and grooming measures".

When interviewed on 9/20/17, at 2:00 p.m. nursing assistant (NA)-C verified oral care and nail care had not been performed for R72.

When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing (IDON) verified the facility expectation for grooming would include nail care every week with bathing and whenever necessary. Oral care would be expected twice a day for all resident's.

R59 did not receive a position change for 4 hours and 15 minutes.

R59 was assessed as at risk for skin breakdown with a stage 2 pressure ulcer on the right gluteal cleft according to the plan of care, dated 8/30/17. Interventions include assist of 1-2 staff to reposition Q2H (every 2 hours) and prn (whenever necessary), total assist of 2 with Hoyer

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2 565	Continued From page 8 (mechanical lift) for transfers, resident does not ambulate. Document review of the facility policy titled, Repositioning, dated May 2013, directed to review the resident's care plan to evaluate for any special needs of the resident. When interviewed on 9/20/17, at 2:30 p.m. nursing assistant (NA)-A, NA-B & NA-C, who were working together,verified repositioning Q2H had not been performed for R72 since getting up into the wheel chair at 10:13 a.m. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing verified the facility expectation for residents assessed with skin breakdown would be to reposition every 2 hours according to the assessment and the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		11/1/17

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2 830	Continued From page 9 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not complete a physician order of daily weights for a resident receiving dialysis for 1 of 1 resident (R98) reviewed for dialysis, and based on document review, interview, and observations, the facility failed to establish interventions to reduce risk of falls for 1 of 3 residents (R209) reviewed for accidents, who was identified upon admission as at risk for falls, and fell twice in the facility. Findings include: Record review for R98 revealed a physicians's order, dated 5/26/17, for dialysis Tuesdays, Thursdays, Saturdays. The Order Summary Report also contained a physician's order, dated 6/29/17, that read, "Weight daily before breakfast..." A Weights and Vitals Summary form for R98 from 7/20/17 to 9/21/17 showed only 16 weights recorded. When interviewed on 9/21/17 at 1:47 p.m., licensed practical nurse (LPN)-C stated that it	2 830	Resident #98 is being weighed daily per MD orders. A list of all residents in the facility requiring daily weights was obtained and reviewed. These individuals are having their weights obtained daily per orders. Nursing staff were educated on obtaining daily weights starting on 9/27/2017 and will be ongoing until completion. The facility reviewed the system for obtaining daily weights. Residents with daily weights will be audited daily for 1 month. The DON is responsible for ensuring that daily weights are obtained per MD orders. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 830	Continued From page 10	2 830		

was the responsibility of the nursing assistants to obtain and record the daily weights. She explained that she has noticed in the recent past that the daily weights were not all in the electronic record of R98, and when she reminded the nursing assistants to complete the daily weights they told her that they were doing the daily weights and recording them in the electronic record, and they questioned if there was something wrong with the electronic record software.

The interim director of nursing was interviewed about the missing weights on 9/21/17 at 2 p.m. and she replied that she was not aware of any malfunction of the electronic record software or the weight scales in the facility.

Review of the Pre-Admission Assessment Information form, dated 9/12/17, revealed R209 was being admitted on 9/12/17 with a right hip fracture, and was at risk for falls. R209's face sheet, dated 9/20/17, listed diagnoses including fracture of neck of right femur, and dementia.

R209's undated preliminary care plan had a typed note at the top of the form that this preliminary care plan must be initiated "within 24 hours of admission." The document included a section for designating whether or not the resident was a "Fall Risk" by checking either "Yes" or "No," and underneath the boxes was written, "If yes, implement safety measures." The form contained more boxes to check if any of the following safety measures were in place: sensor, grab bars, floor mat, or other safety measure. There was a line next to "other" for staff to clarify any other safety measures in place for R209. Staff had not checked a box to indicate whether or not R209

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2 830	Continued From page 11 was a fall risk, and did not document that any safety measures were in place for R209. The Kardex Report was a report for nursing assistants to know how to care for residents, and what type of assistance they needed. R209's Kardex Report, dated 9/12/17, included a category for special interventions, which noted that R209 needed a gait belt (a belt worn around the resident's waist for staff to assist with balance while walking or transferring), and limited assistance of one staff person to walk. The report did not specifically indicate R209 was at risk of falling. During interview on 9/19/17, at 11:54 a.m. registered nurse (RN)-B said R209 had fallen twice since admission. The first fall was one day after admission on 9/13/17, and the second on 9/17/17. RN-B described the resident as "very confused." Review of a fall report dated 9/13/17, revealed at 12:25 a.m. R209 fell in the common area. The incident description described R209 standing up in her wheelchair and falling down onto the floor, hitting the left elbow and hip on the floor. No new interventions were noted in this report. Review of a fall report dated 9/17/17, revealed R209 was found in the doorway of the bathroom in the resident's room. The incident description said R209 was found laying on the left side on the floor, and explained was coming back from the bathroom, and fell backwards. The fall progress note dated 9/17/17 revealed R209 was "educated on call light use." No other new interventions were noted on this report. In an an occupational therapy summary of skilled	2 830		

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2 830	Continued From page 12 services completed 9/18/17, regarding service date 9/15/17, the occupational therapist noted attending a care conference with family. The summary described educating R209 on hip precautions, but the patient was unable to recall the precautions discussed after five minutes. The summary also noted R209 was unable to locate the call light to ask for help with toileting. During observation on 9/20/17, at 7:33 a.m. the door to R209's room was open by a couple inches. Through the opening, R209 could be seen sitting on the edge of the bed. Around this time, RN-B was passing in the common area when asked by the surveyor whether R209 was alone in the room, or with a nursing assistant. RN-B knocked on R209's door. R209 replied, "I'm just getting dressed, give me ten more minutes." RN-B asked R209 if there was anyone in the room helping the resident get ready, and R209 replied, "Give me five more minutes." RN-B confirmed that there was nobody currently helping the resident. RN-B said R209 was trying to get dressed, but clarified that R209 needed help, and went to find a nursing assistant to help the resident. At 7:37 a.m. nursing assistant (NA)-D entered R209's room to help. R209 sat at the edge of the bed dressed in a shirt and underwear. NA-D and the resident discussed what clothes to wear that day, and NA-D assisted the resident in dressing. At 7:40 a.m. NA-D explained needing to help R209 put shoes on, and directed the resident to remain seated. NA-D asked whether R209 already went to the bathroom, and R209 replied, "Yes." At this time, R209 began to stand up from the edge of the bed without assistance. NA-D said, "[R209], no, [R209], sit down please! Thank you." R209 sat down on the bed again while NA-D put shoes on the resident, then helped transfer R209 to the wheel chair before	2 830		

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2 830	Continued From page 13	2 830		

bringing R209 to the bathroom sink to wash face and brush teeth. At 7:48 a.m. NA-D said explained that R209 had already taken self to the bathroom that morning without help, because NA-D observed a brief on the bathroom floor, and had to flush the toilet. NA-D also observed R209 was already wearing underwear when NA-D entered the room to help with cares, so NA-D thought R209 must have started getting ready independently that morning. NA-D said R209 was not supposed to walk unassisted, and thought that R209 had previous falls, and came into the facility for falls and dementia. When asked if R209 was able to use a call light, NA-D thought it depended on how urgent the need, explaining if R209 had an urgent need, the resident would probably not use the call light for help.

During interview on 9/20/17, at 11:47 a.m. R209's family member (FM)-F explained that R209 had fallen previously, and knew that staff did not want R209 getting up without help. FM-F thought that R209 would get up and go to the bathroom alone if the resident felt the need to void. FM-F wondered if the facility was short staffed, and worried R209 would get up independently if there was nobody around to help.

During an interview on 9/21/17, at 2:55 p.m. RN-B said staff were not aware of any new interventions after R209's falls, and explained how staff kept R209's call light in reach, reminded R209 to use the call light, and reoriented R209 to the resident's room, and identity of staff.

During interview on 9/21/17, at 3:00 p.m., when asked if R209 had fallen at the facility, NA-E said that R209 had never fallen during NA-E's shift, so NA-E didn't know for sure. NA-E was aware that R209 was at risk for falls, and needed help

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2 830	Continued From page 14 walking. NA-E explained that the resident was always wanting to get up out of bed, then lay back down again, and vice versa. Because of this, NA-E had to keep an eye on the resident and try to ensure the resident was comfortable either in bed, or in the common area, or R209 might try to transfer alone. During interview on 9/21/17, at 3:20 p.m. the assistant director of nursing said staff tried to keep R209 in the common area to keep an eye on the resident, and kept the call light near the resident in R209's room, but that she could not find fall interventions in writing. Review of the Fall Prevention/Reduction Program policy, dated 4/16, revealed all residents would be assessed upon admission to determine the risk for falls. If deemed necessary, the fall prevention/reduction program would be implemented and followed. The policy required, "It will be noted on the [nursing assistant] assignment sheets any resident at high risk for falls." The policy continued, "All falls will be reviewed by the interdisciplinary team. Resident falls will be monitored and appropriate actions taken to prevent repeat occurrences as recommended by the interdisciplinary team members and the recommendations/interventions will be documented in the evaluation of the post fall event.... The resident's care plan will be updated as needed to reflect interventions as appropriate." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies/procedures, train staff and monitor to assure that physician orders are	2 830		

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2 830	Continued From page 15 followed. The Director of Nursing and/or designee could review and revise policies, train staff and monitor to assure interventions are identified and implemented for residents at risk for falls. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal hygiene care for 2 of 3 residents (R59 & R72) in the sample who were dependent upon staff for personal cares. Findings include: R59 was assessed to require staff assistance with nail care and did not receive assistance in accordance with the plan of care interventions. During an observation on 9/19/17, at 9:11 a.m. R59 had fingernails that extended beyond the finger tips greater than 1/4th inch and appeared dirty with dark tan and brown substance accumulated under each nail. Two of the 10 fingernails had broken side, jagged edges.	2 855	Residents number 59 and 72 receive nail care per the facility policy and standards of care. All residents requiring assistance with nail care will are provided these services in accordance with facility standards. The facility provided education on nail care beginning on 9/27/2017 and will be ongoing until completion. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that nail care is provided to residents per	11/1/17

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2 855	Continued From page 16 When interviewed on 9/19/17, at 9:11 a.m. R59 expressed the fingernails are too long and staff had not offered to clean or trim the fingernails. Furthermore, R59 indicated the substance under the nails was from "food" and feeding self without soaking or cleaning the fingernails for "many weeks." During an observation on 9/20/17, at 12:00 p.m. R59 continued to have unclean fingernails and two broken, jagged nails remained present. Document review of R59's Minimum Data Set (MDS) dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 required staff assistance for activities of daily living (ADLs). The plan of care for R59 dated 1/1/17, read, "Staff to trim resident's finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R59. R72 was assessed to require staff assistance with nail care and oral care and did not receive assistance in accordance with the plan of care interventions. During an observation on 9/19/17, at 9:58 a.m. R72 had fingernails that extended beyond the fingertips greater than 1/4th inch and appeared dirty with dark tan and brown substances accumulated under each nail. Furthermore, R72 had a heavy film of tan yellow substance on the upper teeth which R72 indicated was from not being offered assistance to brush teeth every day. R72 had own top teeth but no bottom teeth.	2 855	facility policy and standards of practice. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 855	Continued From page 17 During an observation on 9/20/17, from 7:00 a.m. until 12:00 p.m. R72 was not offered nail care or oral care. R72 stated, "I cannot take care of myself because of the carpal tunnel in both hands, it is just too painful." Furthermore, R72 expressed frustration that the staff do not offer nail care and especially expressed a desire for oral care which the staff have not offered for weeks. Document review of R72's MDS dated 8/25/17, indicated the resident was cognitively intact and the CAA indicated staff assistance for ADL's. The plan of care for R72 dated 3/20/17, read, "Oral Care/Hygiene Provide set up for oral hygiene BID (twice a day) in the AM and at HS (bedtime). Dressing/Personal hygiene/Bathing: Resident needs assist with dressing and grooming due to osteoarthritis and carpal tunnel. Staff to trim Residen't finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R72 Document review of the facility policy titled, Oral Care and Nail Care, dated 11/9/07, read, "To assure adequate hygiene and grooming measures." When interviewed on 9/20/17, at 2:00 p.m. nursing assistant (NA)-C verified oral care and nail care had not been performed for R72. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing verified the facility expectation for grooming would include nail care every week with bathing and whenever necessary. Oral care would be expected twice a day for all residents.	2 855		

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2 855	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review/revise policies, train staff and monitor to assure all residents recieve care in accordance with the plan of care interventions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal hygiene care for 2 of 3 residents (R59 & R72) in the sample who were dependent upon staff for personal cares. Findings include: R59 was assessed to require staff assistance with nail care and did not receive assistance in accordance with the plan of care interventions. During an observation on 9/19/17, at 9:11 a.m. R59 had fingernails that extended beyond the	2 860	Residents number 59 and 72 receive nail care per the facility policy and standards of care. All residents requiring assistance with nail care will are provided these services in accordance with facility standards. The facility provided education on nail care beginning on 9/27/2017 and will be ongoing until completion. Random nail care audits will be completed on 5 residents/week for 4 weeks, 3/week	11/1/17

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2 860	Continued From page 19 finger tips greater than 1/4th inch and appeared dirty with dark tan and brown substance accumulated under each nail. Two of the 10 fingernails had broken side, jagged edges. When interviewed on 9/19/17, at 9:11 a.m. R59 expressed the fingernails are too long and staff had not offered to clean or trim the fingernails. Furthermore, R59 indicated the substance under the nails was from "food" and feeding self without soaking or cleaning the fingernails for "many weeks." During an observation on 9/20/17, at 12:00 p.m. R59 continued to have unclean fingernails and two broken, jagged nails remained present. Document review of R59's Minimum Data Set (MDS) dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 required staff assistance for activities of daily living (ADLs). The plan of care for R59 dated 1/1/17, read, "Staff to trim resident's finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R59. R72 was assessed to require staff assistance with nail care and oral care and did not receive assistance in accordance with the plan of care interventions. During an observation on 9/19/17, at 9:58 a.m. R72 had fingernails that extended beyond the fingertips greater than 1/4th inch and appeared dirty with dark tan and brown substances accumulated under each nail. Furthermore, R72 had a heavy film of tan yellow substance on the	2 860	for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that nail care is provided to residents per facility policy and standards of practice. Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 860	Continued From page 20 upper teeth which R72 indicated was from not being offered assistance to brush teeth every day. R72 had own top teeth but no bottom teeth. During an observation on 9/20/17, from 7:00 a.m. until 12:00 p.m. R72 was not offered nail care or oral care. R72 stated, "I cannot take care of myself because of the carpal tunnel in both hands, it is just too painful." Furthermore, R72 expressed frustration that the staff do not offer nail care and especially expressed a desire for oral care which the staff have not offered for weeks. Document review of R72's MDS dated 8/25/17, indicated the resident was cognitively intact and the CAA indicated staff assistance for ADL's. The plan of care for R72 dated 3/20/17, read, "Oral Care/Hygiene Provide set up for oral hygiene BID (twice a day) in the AM and at HS (bedtime). Dressing/Personal hygiene/Bathing: Resident needs assist with dressing and grooming due to osteoarthritis and carpal tunnel. Staff to trim Residen't finger and toe nails as needed following weekly bath." Document review of the Weekly Skin Assessment for weekly baths the previous 6 weeks verified nail care was not performed for R72 Document review of the facility policy titled, Oral Care and Nail Care, dated 11/9/07, read, "To assure adequate hygiene and grooming measures." When interviewed on 9/20/17, at 2:00 p.m. nursing assistant (NA)-C verified oral care and nail care had not been performed for R72. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing verified the facility	2 860		

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2 860	Continued From page 21 expectation for grooming would include nail care every week with bathing and whenever necessary. Oral care would be expected twice a day for all residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or desigee could review/revise policies and procedures, train staff and monitor to assure that personal hygiene is provided to residents who are dependent upon staff for personal cares. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received timely repositioning for 1 of 3 resident's (R59) in the sample identified at risk for pressure ulcers. Findings include:	2 905	Resident #59 is turned and repositioned q 2 hours per plan of care. Individuals requiring q 2 hour turning and repositioning were identified; they are repositioned per policy. 3 residents/week will be audited for	11/1/17

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2 905	Continued From page 22 R59 did not receive an offer to position change for 4 hours and 15 minutes During an observation on 9/19/17, at 3:00 p.m. R59 was sitting up in the wheel chair in the bedroom. When interviewed on 9/19/17, at 3:00 p.m. regarding the frequency of position changes, R59 indicated it was not unusual to sit up in the wheel chair without any staff offers to change position in the afternoon. R59 was aware of an open area on buttocks but was unable to feel pressure and did not experience pain in the buttocks. Document review of R59's Minimum Data Set (MDS), dated 1/28/17, indicated R59 was cognitively intact and the Care Area Assessment (CAA) indicated R59 had an existing pressure ulcer. The document titled, Braden Scale for Predicting Pressure Sore Risk, dated 7/22/17, verified R59 was at risk for pressure ulcers. Document review of the plan of care dated 8/30/17, indicated R59 was assessed as at risk for skin breakdown with a stage 2 pressure ulcer on the right gluteal cleft. Interventions included assist of 1-2 staff to reposition Q2H (every 2 hours) and prn (whenever necessary), total assist of 2 with Hoyer for transfers, resident does not ambulate. Document review of the physician order, dated 6/6/17, read resident should be up in chair 1-2 hours three times daily. resident should not be up in wheelchair longer than 2 hours at a time, reposition every 2 hours while in bed. Document review of the facility policy titled, Repositioning, dated May 2013, directed to	2 905	repositioning for 4 weeks, 2 residents/week for 4 weeks, and 1/week for 4 weeks. The DON is responsible for ensuring that residents are turned and repositioned per facility standards and standards of practice.	

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2 905	Continued From page 23 review the resident's care plan to evaluate for any special needs of the resident. During continuous observation on 9/20/17, from 7:00 a.m. until 10:13 a.m., R59 remained in bed positioned partially on the right side. There were no offers to change position while in bed. At 10:13 a.m. R59 was transferred from bed using the mechanical lift and positioned in the wheel chair. At 11:00 a.m. R59 left the unit to accompany family who also resided at the facility, and go to lunch in another area of the facility. At 1:17 p.m. R59 returned to the bedroom with family members. At 2:30 p.m. R59 verified staff had not offered any position changes since getting out of bed at 10:13 a.m.. When interviewed on 9/20/17, at 2:30 p.m. nursing assistant (NA)-A, NA-B & NA-C who were working together,verified repositioning Q2H had not been offered or performed for R72 since getting up into the wheel chair at 10:13 a.m. When interviewed on 9/21/17, at 12:21 p.m. the interim director of nursing (IDON) verified the facility expectation for residents assessed with skin breakdown would be to reposition every 2 hours according to the assessment and the plan of care. If a resident refused repositioning to report to the nurse and to reapproach the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could assure that policies/procedures are reviewed, staff trained and monitored to assure that residents identified at risk for pressure ulcers receive timely repositioning.	2 905		

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2 905	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not complete a physician order of daily weights for a resident receiving dialysis and experiencing weight loss for 1 of 1 resident (R98) reviewed for dialysis. Findings include: Record review for R98 revealed a physicians's order, dated 5/26/17, for dialysis Tuesdays, Thursdays, Saturdays. The Order Summary Report also contained a physician's order, dated 6/29/17, that read, "Weight daily before breakfast..." A Weights and Vitals Summary form for R98 from 7/20/17 to 9/21/17 showed only 16 weights recorded. On 7/20/17 R98's weight was listed as 164 lbs. and 140 lbs. on 9/19/17. When interviewed on 9/21/17 at 1:47 p.m.,	2 965	Resident #98 is being weighed daily per MD orders. A list of all residents in the facility requiring daily weights was obtained and reviewed. These individuals are having their weights obtained daily per orders Nursing staff were educated on obtaining MD/NP ordered daily weights starting on 9/27/2017 and will be ongoing until completion. The facility reviewed the system for obtaining daily weights. Residents with daily weight orders will be audited daily for 1 month. The DON is responsible for ensuring that daily weights are obtained per MD orders.	11/1/17

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2 965	Continued From page 25 licensed practical nurse (LPN)-A stated that it was the responsibility of the nursing assistants to obtain and record the daily weights. She explained that she has noticed in the recent past that the daily weights were not all in the electronic record of R98, and when she reminded the nursing assistants to complete the daily weights they told her that they were doing the daily weights and recording them in the electronic record, and they questioned if there was something wrong with the electronic record software. The interim director of nursing was interviewed about the missing weights on 9/21/17 at 2 p.m. and she replied that she was not aware of any malfunction of the electronic record software or the weight scales in the facility. When interviewed on 9/21/17 at 10:27 a.m., registered dietician (RD)-A stated that R98 was on nutritional high risk monitoring related to receiving dialysis. She was also aware that the resident has experienced weight loss in recent months and had been receiving a nutritional supplement and needed more assistance at meals. She explained that she noticed that the daily weights were not consistently in the resident's record and she had spoken with nursing staff about the inconsistency. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review policies/procedures, train staff, monitor to assure Physician orders are followed and that residents on dialysis are offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident	2 965	Issues identified through facility auditing and QA process will be referred to the QAPI Team for input/suggestions.	

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2 965	Continued From page 26 assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, facility Dietary staff failed to prepare and serve food in a manner that ensured food safety. Findings include: During a dining observation on 9/18/17, at 5:13 p.m. 13 residents ate in the Evergreen dining room. Food server (FS)-A was observed serving the residents in the dining room, and also dishing up room trays for residents who ate in their rooms. FS-A wore a hairnet that had slipped up and off the head, and loosely sat around long hair that was secured into a bun at the crown of the head. The slipping hairnet left exposed hairs at the nape of the neck. At 5:19 p.m. FS-A came out of the kitchenette with a plate of food in each hand, and hair coming out of the front of the	21000	DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their hair adequately, they wash their hands and utilize gloves per policy/standards, thermometers are disinfected properly between foods, chemical sanitzer is used in the dish machines and its' tested daily. Dining staff were inserviced beginning 9/27/2017 and will be ongoing until completed on: hairnet usage, handwashing standards, glove use, disinfecting thermometer probes, infection control basics, chemical testing for dish machines, and safe food handling to minimize risk of foodborne illnesses.	11/1/17

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21000	Continued From page 27 hairnet by the face. FS-A was not wearing gloves, set the plates in front of residents, swiped hair away from the face with bare fingers, and went back into the kitchenette to dish up and bring out two more plates of food without performing hand hygiene. After dropping off the plates, FS-A returned to the kitchenette and prepped more plates of food, used the microwave, and pulled silverware from the drawers. A sign on the door to the kitchenette said in all capital letters, "HAIR RESTRAINTS MUST BE WORN IN THIS AREA!" At 5:30 p.m. the dining services director (DSD) entered the kitchenette and asked FS-A about not wearing gloves. The DSD told FS-A to fix the hairnet that was falling off. FS-A was heard asking, "Is it falling off again?" After fixing the hairnet, The DSD reminded FS-A to wash hands after tucking stray pieces of hair back in the hairnet. FS-A turned on the water and washed hands. At 5:51 FS-A entered the dining room with gloves on, and collected dirty cloth napkins from tables to be cleaned. FS-A returned to the kitchenette with the gloves on, picked up some creamer packets with the same gloved hands, and then served up more food on a plate without changing gloves or performing hand hygiene. In an interview on 9/18/17, at 5:55 p.m. FS-A confirmed the hairnet was sliding off during dining service, and explained not realizing it until the DSD mentioned it. When asked about the policy for glove use, FS-A said the previous dietary services director told staff they did not have to wear gloves if they did not have any contact with food. Now there was a newer DSD, and FS-A was not sure if the rules about glove use had changed. In a follow-up interview at 6:04 p.m. the DSD, expected staff to wash and dry hands before wearing gloves, and then change gloves after touching the face, hair, or other non-food	21000	3 audits/week X4 weeks, 2 audits/week X4 weeks, 1 audit/week X4 weeks will be completed on hairnet compliance, handwashing, dish machine chemical testing, glove use, and general infection control issue. follow up. Results of the audits will be reviewed at QAPI. The Dining Services Manager is responsible for this area.	

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21000	Continued From page 28 surfaces. The DSD expected staff to wash and dry hands between glove changes, and to cover all hair in a hairnet. Review of the Handwashing policy, dated 3/9/16, revealed the following examples, among others, when dining services staff were expected to wash hands: before serving food, after bussing dishes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review policies, train staff and monitor to assure that dietary staff cover their hair and thoroughly wash hands during food prep and serve food in a manner that ensures food safety. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare and serve food in a manner that ensured food safety, and failed to wash dishes at temperatures appropriate for sanitization. This had the potential to affect 37 of 53 residents (residents living on Evergreen and Hawthorn units) in the facility at the time of	21015	DS-A is no longer with St. Therese of Woodbury. Staff wear hairnets covering their hair adequately, they wash their hands and utilize gloves per policy/standards, thermometers are disinfected properly	11/1/17

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21015	Continued From page 29 survey. Findings include: During a dining observation on 9/18/17, at 5:13 p.m. 13 residents ate in the Evergreen dining room. Food server (FS)-A was observed serving the residents in the dining room, and also dishing up room trays for residents who ate in their rooms. FS-A wore a hairnet that had slipped up and off the head, and loosely sat around long hair that was secured into a bun at the crown of the head. The slipping hairnet left exposed hairs at the nape of the neck. At 5:19 p.m. FS-A came out of the kitchenette with a plate of food in each hand, and hair coming out of the front of the hairnet by the face. FS-A was not wearing gloves, set the plates in front of residents, swiped hair away from the face with bare fingers, and went back into the kitchenette to dish up and bring out two more plates of food without performing hand hygiene. After dropping off the plates, FS-A returned to the kitchenette and prepped more plates of food, used the microwave, and pulled silverware from the drawers. A sign on the door to the kitchenette said in all capital letters, "HAIR RESTRAINTS MUST BE WORN IN THIS AREA!" At 5:30 p.m. the dining services director (DSD) entered the kitchenette and asked FS-A about not wearing gloves. The DSD told FS-A to fix the hairnet that was falling off. FS-A was heard asking, "Is it falling off again?" After fixing the hairnet, The DSD reminded FS-A to wash hands after tucking stray pieces of hair back in the hairnet. FS-A turned on the water and washed hands. At 5:51 FS-A entered the dining room with gloves on, and collected dirty cloth napkins from tables to be cleaned. FS-A returned to the kitchenette with the gloves on, picked up some creamer packets with the same gloved hands,	21015	between foods, chemical sanitzer is used in the dish machines and its' tested daily. Dining staff were inserviced beginning 9/27/2017 and will be ongoing until completed on: hairnet usage, hand washing standards, glove use, disinfecting thermometer probes, infection control basics, chemical testing for dish machines, and safe food handling to minimize risk of foodborne illnesses. 3 audits/week X4 weeks, 2 audits/week X4 weeks, 1 audit/week X4 weeks will be completed on hairnet compliance, hand washing, dish machine chemical testing, glove use, and general infection control issues. Results of the audits will be reviewed at QAPI. The Dining Services Manager is responsible for this area.	

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21015	Continued From page 30 and then served up more food on a plate without changing gloves or performing hand hygiene. In an interview on 9/18/17, at 5:55 p.m. FS-A confirmed the hairnet was sliding off during dining service, and explained not realizing it until the DSD mentioned it. When asked about the policy for glove use, FS-A said the previous dietary services director told staff they did not have to wear gloves if they did not have any contact with food. Now there was a newer DSD, and FS-A was not sure if the rules about glove use had changed. In a follow-up interview at 6:04 p.m. the DSD, expected staff to wash and dry hands before wearing gloves, and then change gloves after touching the face, hair, or other non-food surfaces. The DSD expected staff to wash and dry hands between glove changes, and to cover all hair in a hairnet. Review of the Handwashing policy, dated 3/9/16, revealed the following examples, among others, when dining services staff were expected to wash hands: before serving food, after bussing dishes. During observation of food preparation in the kitchen on 9/21/17, at 11:10 a.m. Cook (C)-A placed thawed, raw meat patties inside of a chilled drawer that was underneath the grill. C-A said they were to be cooked later. C-A inserted a probe thermometer inside the raw meat patties to ensure they were below 40 degrees Fahrenheit (F). Between checking temperatures of different pieces of raw meat, C-A quickly wiped the probe of the thermometer one time on a wet towel. After checking the temperature of the raw meat, C-A again quickly wiped the probe one time on the wet towel, then immediately proceeded to use the same probe thermometer to check the temperature of ready to eat foods on the chilled	21015		

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21015	Continued From page 31	21015		

salad cart, such as chicken salad, egg salad, mayonnaise, onion, tomato, and other fresh, ready to eat vegetables. Between taking the temperature of each food item, C-A wiped the probe one time on the wet towel. When asked about using the same thermometer from the raw meat to the ready to eat foods, C-A explained that the towel was soaked in Multi-Quat Sanitizer solution.

During interview on 9/21/17, at 11:27 a.m., the dining services director (DSD) was not sure if it was okay for the same thermometer probe to be used on raw meat, wiped with the Multi-Quat Sanitizer, and then immediately used on ready to eat foods, but wanted to call and ask the representative from the company that manufactured the Multi-Quat Sanitizer. C-A explained being trained that it was okay to use the same thermometer on raw meat, and then ready to eat foods, as long as it was wiped with a Multi-Quat Sanitizer soaked towel. At 11:35 a.m. The manufacturer representative spoke to the DSD over the phone, and clarified that a Multi-Quat Sanitizer saturated towel disinfected food contact surfaces after approximately one minute. At 11:41 a.m. the DSD told dining staff to pull all the food off the chilled salad cart before serving residents, and replace it with fresh food, just in case there had been contamination from the temperature probe.

Review of a manufacturer information sheet about Multi-Quat Sanitizer revealed the following directions for use: "Apply Oasis 146 Multi-Quat Sanitizer at proper use solution. Expose all surfaces of equipment, ware or utensils to the sanitizing solution for a period of not less than one minute. Air dry."

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21015	Continued From page 32 During the initial kitchen tour on 9/18/17, at 12:28 p.m. the dietary services director (DSD) explained the EC-44 Dishmachine used high temperatures to clean. High temperature machines sanitize dishes using hot water, rather than chemicals. During observation of the EC-44 Dishmachine on 9/21/17, at 11:56 a.m. the dishwasher (D)-E said the water temperatures would get low. D-E said the dishmachine had been like this for a while, and explained after the machine ran for a long time throughout the day, the temperatures dropped. D-E said the wash temperature drops first, and then the rinse temperature "goes next." D-E said the previous night, temperatures dropped until the wash temperature was around 140 degrees Fahrenheit (F), and the final rinse temperature dropped below 170 degrees F. D-E logged water temperatures on a Dishwasher Temperature Log, and the September 2017 log showed temperatures were frequently lower than required. On 9/13/17, the wash and rinse temperatures dropped as low as 135 degrees F and 165 degrees F, respectively. Type on the bottom of the Dishwasher Temperature Log required, "Wash temperature must reach 150 [degrees F]" and "Rinse temperature must reach 180 [degrees F]". Review of the EC-44 Dish machine manufacturer information sheet revealed the following machine specifications for high temperature sanitization: Wash temperature: 160 degrees F. Sanitizing rinse: 180 degrees F. The DSD explained being previously unaware of the temperature problems, and called the manufacturer on 9/21/17 at 12:04 p.m. to request that they visit the facility and look at the dish machine.	21015		

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21015	Continued From page 33 During an interview on 9/21/17, at 2:15 p.m. the administrator clarified that the EC-44 Dish machine in the kitchen washed all the dishes for the Evergreen and Hawthorn units, but that the Rosewood unit had its own dishwasher. The administrator explained that the EC-44 Dish machine used a temperature booster to boost the temperature up to 70 degrees higher. The administrator described how the hot water temperature in the facility was capped at 115 degrees F to prevent burns. Consequently, if the water temperature cooled more than 5 degrees before reaching the kitchen dish machine, then the booster was not able to boost the temperature to 180 degrees F, resulting in water temperatures that were too cool. Because of the risk of low temperatures, the administrator said kitchen staff had just implemented a chemical that day to be used in the dish machine, which would sanitize the dishes at lower water temperatures. Additionally, the facility had not implemented a comprehensive infection control program to include consistent tracking, trending, and analysis of illnesses in the facility, including but not limited to foodborne illness, and other gastrointestinal illness, that could potentially result from food contamination, poor hand hygiene, and improper dishwashing. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review policies, train staff and monitor to assure sanitary procedures and conditions are maintained in the operation of the dietary department at all times.	21015		

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21015	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had the potential to affect all 53 residents, staff and visitors in the facility. The facility also failed to use infection control measures during a dressing change for one of one resident (R7) observed during a dressing change. In addition, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring and hand hygiene for 6 of 6 residents (R77, R90, R93, R202, R205, R210), observed, who required blood glucose monitoring, and failed to properly sanitize 1 of 1 resident's (R59) urinary catheter drainage bag and tubing. Findings include: During a random interview on 9/20/17 at approximately 1:00 p.m. the administrator reported there were no up to date infection	21375	Resident #59 has a new catheter system in place. Residents with a catheter have the new system. Glucometers are disinfected after each use. The facility has implemented an infection control prevention and control program that includes the required elements of identifying, implementing, monitoring, and reporting of infections. Infection Control logs are kept per facility policy and regulations. Staff have been re-educated beginning on 9/27/2017 on handwashing, glucometer disinfecting, glove use, as well as other infection control basics/polices. Infection control rounds/audits will be completed 3X's/week by the Infection Control Preventionist, or her qualified designee, to ensure infection control practices are being adhered to in the facility. The outcome of these audits will	11/1/17

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21375	Continued From page 35 control logs that would include ongoing tracking and trending of resident infections. On 9/21/17 at 12:30 p.m. the interim director of nursing (IDON) reported the system for infection control monitoring had not been kept up since after March 2017. The IDON had contacted the previous staff person for additional information and was unable to obtain such information. For the months of January, February and March names of residents, room numbers, diagnoses and treatment were identified in the three month documentation, however, there was no analysis completed. The IDON was unaware of how data was collected from various units and indicated that going forward, would include information from the pharmacy as well as laboratory reports. The surveillance logs did not identify if residents were admitted with infections or if the infections were acquired at the facility. There was no identification of the organism and no identification of resolution dates of the illness. Documentation lacked specific infections, organisims, whether community based or house acquired. The IDON confirmed that no further monitoring of patient infections had occurred since March 2017. When asked when infection control was discussed at the facility's quality assurance (QA) meeting, on 9/22/17 at approximately 11:00 a.m., the administrator indicated infection control was to be discussed quarterly, but will be changed to monthly review in the future. An infection control policy was requested, however not provided. On 9/20/17 at 1:30 p.m. a random observation of	21375	be reviewed monthly at the IC meeting for trends and tracking. The implemented IC log will also be reviewed monthly by the Team. Issues identified with IC practices, including catheter cleaning, will be reviewed by the QAPI Team quarterly for their input/suggestions. The Infection Control Preventionist is responsible for ensuring that the facility has a comprehensive IC program in place at the facility.	

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a dressing change, for an excoriated area, for R7 was made. The registered nurse (RN)-A entered the room, washed hands and applied gloves. Two nursing assistants were assisting with holding R7 on the right side exposing the buttocks and sacral area. The old dressing had been removed and the area appeared excoriated and red. RN-A sprayed a cleansing spray onto a 4 x 4 inch gauze square and cleansed the area, tossed the gauze onto a wrapper paper and again sprayed the cleansing spray onto another 4 x 4 gauze square and cleansed the area of the excoriated buttocks. The area was approximately 6 cm x 4 cm across the upper half of both buttocks. RN-A used a pen from the pocket of uniform and dated the dressing. RN-A placed paper and dressing papers on top of an opened dressing envelope. RN-A donned another pair of gloves, without washing hands or using alcohol solution, and proceeded to press a dressing over the excoriated area on the sacral and buttocks area. When finished, RN-A picked up the remaining dressing debris and disposed of it in the trash. RN-A removed gloves and then used hand sanitizer gel that was clipped to uniform. RN-A left the room. When interviewed regarding the procedure, RN-A acknowledged she had forgotten to wash hands after removing the soiled gloves.

On 9/21/17 at 12:25 p.m. the Interim director of nursing was asked about glove changes and verified the registered nurse should have washed hands after cleansing the area and before putting on clean gloves.

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21375	Continued From page 37 During an observation on 9/18/17, at 4:13 p.m. of blood glucose monitoring, licensed practical nurse (LPN)-B entered R202's bedroom carrying the container of glucometer supplies. LPN-B set the container on the tray table and without washing/sanitizing hands donned a pair of gloves, obtained R202's blood, set the contaminated glucometer in with the clean supplies, removed gloves, left the room and while walking down the hallway, retrieved a ringing phone from the uniform pocket, answered the phone, and then set the phone back at the nurses station. LPN-B then sanitized the glucometer machine for 10 seconds with a wipe. LPN-B did not wash/sanitize hands. During an observation on 9/18/17, at 4:36 p.m. LPN-B took the glucometer container to R210 and set the container with the glucometer supplies on R210's personal arm chair in the bedroom. LPN-B obtained gloves from the bathroom without washing/sanitizing hands and obtained blood from R210. LPN-B removed gloves and washed hands with running water for 6 seconds. LPN-B put the contaminated glucometer into the container, left the room and sanitized the glucometer at the med cart using the wipe for 15 seconds, then returned the glucometer to the container. During an observation on 9/18/17, at 4:29 p.m. LPN-B took the container with glucometer supplies to R205, set the container on the counter, retrieved the glucometer, no hand hygiene and donned gloves to obtain the blood glucose reading. LPN-B set the contaminated glucometer in the container, removed gloves, did not wash/sanitize hands, and proceeded back to the med cart and sanitized the glucometer with a wipe for 15 seconds and put the glucometer back	21375		

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into the container. LPN-B then sanitized hands with alcohol gel.

When interviewed on 9/18/17, at 4:45 p.m. LPN-B was not sure how many seconds the glucometer was to be sanitized with the wipe and was not aware of the time spent but stated, "For a while."

During an observation on 9/20/17, at 7:05 a.m. trained medication aide (TMA-A) took the glucometer container and supplies to R77's bedroom, and set the container on the tray table. TMA-A donned gloves without washing/sanitizing hands, obtained the blood test and without sanitizing the glucometer machine put it back in the container with the clean supplies. TMA-A removed gloves and left the room. TMA-A did not wash/sanitize hands or the glucometer machine.

During an observation on 9/20/17, at 7:15 a.m., TMA-A took the glucometer container supplies into R93, set the glucometer container on the tray table, donned gloves from the bathroom supply, obtained blood from R93 and without sanitizing the machine, put it back in the container. removed gloves and left the room without washing/sanitizing hands or glucometer.

During an observation on 9/20/17, at 7:30 a.m. TMA-A entered the room of R90, set the glucometer container on the tray table and at the sink washed the palms of hands for 7 seconds, donned gloves taken from uniform pocket, After obtaining blood from R90, TMA-A put the contaminated glucometer back into the container, took a pen out of the uniform pocket and wrote down the glucometer number, then removed contaminated gloves, retrieved the glucometer container and took the supplies back to the med cart. TMA-A documented the blood sugar in the

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computer using the computer mouse to navigate the documentation. Then, TMA-A sanitized hands with alcohol gel . There was no cleaning of the glucometer.

When interviewed on 9/20/17, at 11:59 a.m. TMA-A verified not sanitizing the glucometer in-between resident use because did not know they were supposed to sanitize the machine in-between uses. TMA-A did not know what product was to be used to sanitize the glucometer and did not know there was a required period of time for the sanitizing depending on the wipe used and manufacturer recommendations.

Document review of the facility policy, titled; Glucometer:Cleaning and Care, dated August 2012, directed Glucometers will be cleaned after each use and cared for properly. To ensure consistency in testing and results and prevent the spread of infection and infectious diseases. The cleaning procedure Disinfect meter with germicidal disposable wipes and follow manufacturer's guidelines for dry time,

Document review of the facility Safety Data Sheet dated January 5, 2015 indicated moistened disinfecting bleach wipes of 1:10 concentration of sodium hypochlorite (bleach). required a 2 minute saturation time on the glucometer and then allow to air dry.

Document review of the facility policy titled; Handwashing, dated March 9, 2016, directed staff to apply soap over the entire hands and wrists and to rub hands vigorously together for at least 20 seconds. Furthermore, the policy directed Hand Sanitizer (Not a replacement for hand washing. Use only after washing hands) and spread over complete surface of hands (front and

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21375	Continued From page 40 back) and Rub until dry. Document review of the policy titled; Disposable glove use, dated June 1, 2017, directed staff to wash hands immediately after glove removal. When interviewed on 9/20/17, at 12:30 p.m. the interim director of nursing (IDON) verified staff are to wash hands before and after removing gloves, and the glucometers are to be disinfected with the bleach product for 2 minutes per manufacturer recommendations R59's cares were observed on 9/20/17, at 10:00 a.m. Nursing assistant (NA)-B was in the R59's bathroom, tending to a foley catheter bag. NA-B poured 4 ounces of vinegar into the connection tubing of R59's foley catheter bag. Then, NA-B swished the vinegar in the foley bag and released the bottom valve and drained the vinegar into the toilet. NA-B then ran running water from the sink into the connection tubing of the foley catheter bag and emptied that into the toilet. NA-B hung the foley catheter bag on the shower hand rail and there was no cap on the end of the tubing. Document review of an undated policy titled; Urinary Catheter Daily Cares and Bag Change Skills Competency Checklist, read; a. Clean the bag with soapy water, b. Rinse the bag well with clean tap water, c. Soak the bag for 30 minutes in a solution of one part vinegar to three parts water, d. Empty the bag, e. Air dry the bag, f. If available, put a cap that has been disinfected with alcohol on the connecting tip, g. Replace tubes and catheter bags that are cracked, hardened, or difficult to see into.	21375		

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21375	Continued From page 41 When interviewed on 9/20/17, at 12:30 p.m., the IDON explained not being familair with how staff cleaned catheter bags/tubing, was not familiar with pouring undiluted vinegar into the catheter tubing, and would need to do some audits. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review policies, train staff and monitor to assure an infection control program has been established and maintained to provide a safe and sanitary environment for residents, staff and visitors. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the	21530		11/1/17

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21530	Continued From page 42 pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review and interview, the pharmacist failed to identify and report irregularities to the attending physician, facility medical director, and director of nursing, when 1 of 5 residents (R48) reviewed for unnecessary medications received excessive doses of acetaminophen (greater than 4,000 milligrams) in a 24 hour period. Findings include: Review of the admission record revealed R48 admitted to the facility on 8/19/17. Since admission, providers prescribed R48 various medication orders for acetaminophen (common	21530	Resident number 48's medication regimen was reviewed for total mg of Acetaminophen potential per day. The MD/NP was updated and orders changed to ensure that if resident took all allowable PRN doses, that she would not exceed 4 grams of Acetaminophen. All resident's medication regimen has been reviewed by the consultant pharmacist for Acetaminophen amounts to ensure they do not exceed 4 grams/day. The nursing staff were inserviced on Acetaminophen dosing regulations	

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21530	Continued From page 43 brand name: Tylenol), both at scheduled times and as needed for pain. According to the United States Food and Drug Administration (FDA) website, "Acetaminophen can cause serious liver damage if more than directed is used." The current standard of practice for adults is not to exceed 4,000 milligrams (mg) of acetaminophen in a 24 hour period. Review of the Consultant Pharmacist Communication to Physician form revealed that the pharmacist reviewed R48's medication regimen on 9/7/17. The pharmacist did not note excessive acetaminophen doses given to R48, or potential for excessive acetaminophen doses on the communication form. Review of the medication administration record revealed R48 received greater than 4,000 mg of acetaminophen on the following days prior to the pharmacist's visit on 9/7/17: -8/24/17: received 4,950 mg -8/26/17: received 4,450 mg -8/27/17: received 4,600 mg Review of acetaminophen orders since admission revealed the following history of provider orders: -Acetaminophen Tablet 500 mg: give 1000 mg by mouth at bedtime for pain. Started 8/24/17 at 1900. Discontinued 8/24/17 at 2104. -Acetaminophen Tablet 500 mg: give 1000 mg by mouth one time a day for pain. Started 8/26/17 at 2000. Discontinued 8/29/17 at 1237. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give one tablet by mouth one time a day for pain for 7 days. started 8/29/17 at 2100. Completed 9/4/17. -Acetaminophen Tablet 500 mg: Give 500 mg by	21530	beginning on 10/11/2017 and ongoing until completed. The consultant pharmacist reviews medications regimens monthly to audit for Acetaminophen dosing, his/her findings will be sent to the DON for order changes. Random new admission audits will be completed for Acetaminophen dosing: 3 residents/week for 4 weeks, 2 residents/week for 4 weeks, and 1 resident/week for 1 week. The consultant pharmacist is responsible for completing a medication regimen review monthly for each resident. The Pharmacist will review her audit reports at QAPI with the Team for areas of improvement. Results of the audits will be forwarded to the facility's QAPI meeting for input/suggestions.	

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21530	Continued From page 44 mouth three times a day for osteoarthritis. Maximum (Max) Acetaminophen dose: 3000 mg/24 hours. Started 8/25/17 at 0800. Discontinued 8/29/17 at 1237. -Acetaminophen Tablet 500 mg: give 500 mg by mouth three times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/29/17 at 1800. Discontinued 9/21/17 at 1406. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/19/17 at 1700. Discontinued 8/24/17 at 1211. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/24/17 at 1700. Discontinued 8/24/17 at 2104. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/19/17 at 1530. Discontinued 8/29/17 at 1236. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg /24 hours. Started 8/29/17 at 1530. Discontinued 8/29/17 at 1630. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/29/17 at 1630. Calculating the total prescribed acetaminophen in the orders above revealed R48 had the potential to receive greater than 4,000 mg acetaminophen on many days if the medication was given as scheduled, and if R48 had requested all available "as needed" orders. Listed below are dates prior	21530		

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	31025	A. BUILDING: _____ B. WING _____	09/22/2017

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21530	Continued From page 45 to the pharmacist's visit on 9/7/17, when the total acetaminophen staff could have potentially given per provider order exceeded 4,000 mg: -8/20/17-8/23/17: Potential of 4,600 mg -8/24/17: Potential of 5,600 mg -8/26/17-8/28/17: Potential of 5,100 mg -8/29/17-9/4/17: Potential of 4,425 mg -9/5/17-9/7/17: Potential of 4,100 mg Additionally, at the time of the pharmacist's medication regimen review on 9/7/17, there were conflicting maximum daily acetaminophen limits, as can be seen in the order list above. One order listed a maximum of 3,000 mg/24 hours, and another listed 4,000 mg/24 hours. During interview on 9/21/17, at 3:57 p.m. the pharmacist confirmed visiting the facility once a month to review medications, and said medication limits were part of that review. The pharmacist reviewed R48's record, and saw an order with a 4,000 mg daily limit for acetaminophen. The pharmacist said the expectation was for staff to follow the order and give no more than 4,000 mg per day. During interview on 9/22/17, at 9:38 a.m. the administrator said the facility did not have a specific policy written about daily acetaminophen limits, but that they were to follow the standard limit of no more than 4,000 mg of acetaminophen daily. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be	21530		

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21530	Continued From page 46 educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on document review and interview, the	21535	Resident number 48's medication regimen	11/1/17

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21535	Continued From page 47 facility failed to ensure residents did not receive excessive medication doses when 1 of 5 residents (R48) reviewed for unnecessary medications received excessive doses of acetaminophen (greater than 4,000 milligrams) in a 24 hour period, and failed to identify non-pharmacological interventions for the use of an antidepressant for sleep for 1 of 5 residents (R66) who was reviewed for unnecessary medication. Findings include: Review of the admission record revealed R48 admitted to the facility on 8/19/17. Since admission, providers prescribed R48 various medication orders for acetaminophen (common brand name: Tylenol), both at scheduled times and as needed for pain. According to the United States Food and Drug Administration (FDA) website, "Acetaminophen can cause serious liver damage if more than directed is used." The current standard of practice for adults is not to exceed 4,000 milligrams (mg) of acetaminophen in a 24 hour period. Review of the medication administration record revealed R48 received greater than 4,000 mg of acetaminophen on the following days since admission to the facility: -8/24/17: received 4,950 mg -8/26/17: received 4,450 mg -8/27/17: received 4,600 mg -9/10/17: received 4,100 mg -9/19/17: received 4,100 mg Review of acetaminophen orders since admission revealed the following history of provider orders:	21535	was reviewed for total mg of Acetaminophen potential per day. The MD/NP was updated and orders changed to ensure that if resident took all allowable PRN doses, that she would not exceed 4 grams of Acetaminophen. Resident #66 has a sleep careplan with nonpharmacological interventions identified. All resident's medication has been reviewed for Acetaminophen amounts to ensure they do not exceed 4 grams/day. Residents taking a medication for sleep have a sleep careplan with nonpharmacological interventions. The nursing staff were inserviced on Acetaminophen dosing regulations and sleep careplans with nonpharmacological interventions beginning on 10/11/2017 and ongoing until completed. The consultant pharmacist reviews medications regimens monthly to audit for Acetaminophen dosing, his/her findings will be sent to the DON for order changes. Random new admission audits will be completed for Acetaminophen dosing and nonpharmacological interventions: 3 residents/week for 4 weeks, 2 residents/week for 4 weeks, and 1 resident/week for 1 week. The DON is responsible for ensuring that the Pharmacist recommendations are acted upon and that sleep careplans are developed with inclusion of nonpharmacological interventions are included. The Pharmacist will review her audit reports at QAPI with the Team for	

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21535	Continued From page 48 -Acetaminophen Tablet 500 mg: give 1000 mg by mouth at bedtime for pain. Started 8/24/17 at 1900. Discontinued 8/24/17 at 2104. -Acetaminophen Tablet 500 mg: give 1000 mg by mouth one time a day for pain. Started 8/26/17 at 2000. Discontinued 8/29/17 at 1237. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give one tablet by mouth one time a day for pain for 7 days. started 8/29/17 at 2100. Completed 9/4/17. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth three times a day for osteoarthritis. Maximum (Max) Acetaminophen dose: 3000 mg/24 hours. Started 8/25/17 at 0800. Discontinued 8/29/17 at 1237. -Acetaminophen Tablet 500 mg: give 500 mg by mouth three times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/29/17 at 1800. Discontinued 9/21/17 at 1406. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/19/17 at 1700. Discontinued 8/24/17 at 1211. -Acetaminophen Tablet 500 mg: Give 500 mg by mouth four times a day for osteoarthritis. Max Acetaminophen dose: 3,000 mg/24 hours. Started 8/24/17 at 1700. Discontinued 8/24/17 at 2104. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/19/17 at 1530. Discontinued 8/29/17 at 1236. -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg /24 hours. Started 8/29/17 at 1530. Discontinued 8/29/17 at 1630.	21535	areas of improvement. Results of the audits will be forwarded to the facility's QAPI meeting for input/suggestions.	

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21535	Continued From page 49 -Hydrocodone-Acetaminophen Tablet 5-325 mg: Give 2 tablet by mouth every 6 hours as needed for pain. Max Acetaminophen dose: 4,000 mg/24 hours. Started 8/29/17 at 1630. Calculating the total prescribed acetaminophen in the orders above revealed R48 had the potential to receive greater than 4,000 mg acetaminophen on many days if the medication was given as scheduled, and if R48 had requested all available "as needed" orders. Listed below are dates when the total acetaminophen staff could have potentially given per provider order exceeded 4,000 mg: -8/20/17-8/23/17: Potential of 4,600 mg -8/24/17: Potential of 5,600 mg -8/26/17-8/28/17: Potential of 5,100 mg -8/29/17-9/4/17: Potential of 4,425 mg -9/5/17-9/20/17: Potential of 4,100 mg During interview on 9/21/17, at 1:08 p.m. registered nurse (RN)-C reviewed the medication administration record for September and verified that on 9/10/17 and 9/19/17, R48 received 4,100 mg of acetaminophen. RN-C confirmed the acetaminophen orders on those dates, and verified that giving the medication as ordered meant that R48 received greater than 4,000 total mg acetaminophen in one day. RN-C confirmed R48 had conflicting maximum acetaminophen limits within the medication orders, and was asked whether R48 should have no more than 3,000 mg or 4,000 mg acetaminophen daily. RN-C followed up with the provider, and confirmed at 1:52 p.m. that R48's maximum daily limit was supposed to be 4,000 mg of acetaminophen. During interview on 9/22/17, at 9:38 a.m. the administrator calculated the total acetaminophen	21535		

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21535	Continued From page 50 given by staff on 8/27/17, and confirmed R48 received 4,600 mg acetaminophen, based on the medication administration record. The administrator said the facility did not have a specific policy written about daily acetaminophen limits, but that they were to follow the standard limit of no more than 4,000 mg of acetaminophen daily. R66 's current physician orders indicated the resident had a diagnosis of insomnia, and was prescribed Trazodone HCl 25 mg orally at bedtime for insomnia. The quarterly minimum data set (MDS) dated 7/6/17 indicated the resident had diagnoses of dementia and psychotic disorder. The MDS indicated R66 was taking antipsychotic and antidepressant medications. A review of the electronic current care plan was completed on 9/20/17. The care plan did not reflect any identification of a problem with insomnia and did not identify any nonpharmacological interventions for insomnia. On 9/21/17 at 1:15 p.m. the interim director of nursing reviewed the care plan and verified insomnia was not included in the care plan and did not identify nonpharmacological interventions for insomnia. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designeed could review policies, physician orders, train staff and monitor to ensure residents do not receive	21535		

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21535	Continued From page 51 excessive medication doses of acetaminophen (greater than 4,000 milligrams) in a 24 hour period, and to identify non-pharmacological interventions for the use of antidepressant used for sleep. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		