Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 6, 2025

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: March 20, 2025

Dear Administrator:

On April 30, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 6, 2025

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: Reinspection Results
Event ID: CNRH12

Dear Administrator:

On April 30, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 20, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 7, 2025

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: March 20, 2025

Dear Administrator:

On March 20, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by June 20, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 20, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 03/20/2025

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 3/17/25 through 3/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56329981C/MN111310, H56329281C/MN104425, H56329263C/MN107876. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		4/24/25

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

Electronically Signed | 04/15/2025

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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F 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 residents (R147, R198) reviewed for Physician Orders for Life Sustaining Treatment (POLST) had the correct code status (i.e. full code, do not resuscitate-DNR) information outlined within the medical record. This could cause R147 and R198 to receive resuscitation efforts (i.e.	F 578	1.) Resident R147 discharged from the facility on 3/28/25 and R198 discharged from facility on 03/19/25 2.) Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected.	

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F 578	Continued From page 2 cardiopulmonary resuscitation-CPR) against their wishes. Findings include: R198 R198's 5-day Minimum Data Set (MDS) dated 3/18/25, indicated R198 was cognitively intact. R198's diagnoses included osteoarthritis of right shoulder, congestive heart failure, chronic kidney disease, and hypertension. R198's face sheet printed 3/17/25 at 7:50 p.m., indicated R198's advance directive listed full code. R198's admission assessment dated 3/12/25, indicated, "Code Status ON HOSPITAL ORDERS: Full Code/CPR...Code Status ON ADMISSION POLST: DNR/DNI...Does the code status on the hospital orders MATCH the code status on the admission POLST orders?: No." The admission assessment indicated in bold, red print, "Code status on hospital order DOES NOT match admission POLST orders!!! Nurse must call provider immediately and get a verbal order confirmation of code status." R198's care plan printed 3/17/25, indicated, "POLST: Resident has completed a POLST: Full code ...Resident wishes will be followed and respected ...See Orders for current Resuscitation order." R198's physician orders dated 3/13/25, indicated, "Full Code ...Active." R198's POLST signed by R198 3/12/25,	F 578	3.) The Director of Nursing (DON) educated licensed nurses regarding the documentation procedures for Advance Directives/Code Status. A chart audit of all residents was completed on 04/14/25. Discrepant findings were addressed immediately, and all actions were completed on 04/14/25. DON reviewed facility policies and procedures which remain current. 4.) DON or designee to complete audits to be completed on all TCU admissions once weekly for 1 month, then every other week for 1 month. After 2 months the DON or designee will complete a random record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained.	

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F 578	Continued From page 3 indicated, "Do Not Attempt Resuscitation/DNR [Allow Natural Death] ...Comfort Focused Treatment." During interview on 3/17/25 at 6:45 p.m., R198 stated would not want CPR, "no pounding on my chest" if found unresponsive and without a heartbeat. R198 stated would not want any tubes or other artificial means to be kept alive. During interview on 3/17/25 at 6:59 p.m., registered nurse (RN)-A stated the POLST could be found in the hard chart and code status could also be seen in the electronic medical record (EMR). RN-A stated the EMR should match the POLST. During interview on 3/17/25 at 7:04 p.m., RN-B stated I would look in the hard chart for the POLST and the code status would also be in the computer. RN-B stated the hard chart should match the EMR, but sometimes the EMR was not updated. During interview on 3/17/25 at 7:39 p.m., RN-A stated R198 was a DNR/DNI according to the POLST located in R198's hard chart. RN-A then looked in R198's EMR and verified R198's face sheet indicated R198 was full code. RN-A stated if a nurse were to look in the computer first, they would think R198 wanted full resuscitation which was against her wishes. During interview on 3/17/25 at 7:49 p.m., RN-C stated the EMR should match the POLST which should reflect the resident's wishes. RN-C stated if the EMR indicated a resident was full code and the POLST indicated DNR, it could be possible the resident would receive resuscitation efforts	F 578		

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F 578	Continued From page 4 when they really wanted DNR. During interview on 3/18/25 at 11:03 a.m., RN-D stated upon admission the nurse would complete an assessment on the resident which included current code status. RN-D stated part of the assessment was to determine what the hospital had documented as code status which would be their admission code status and determine if that was still accurate. The admission assessment worksheet in the EMR would indicate a warning in red when the resident's current code status wish did not match the admission order code status. The warning instructed the nurse to contact the provider immediately to update the order to match the resident's wishes. RN-D stated it was important to have the POLST and EMR to match and also to reflect the resident's current code status wishes. During interview on 3/18/25 at 1:01 p.m., director of nursing (DON) stated expectation for admission nurse to complete a new POLST on every resident and confirm the EMR accurately reflected the POLST which would reflect the resident's accurate code status wishes. DON stated expectation for the code status to be updated timely and be accurate throughout the resident's EMR and hard chart. R147 R147's face sheet printed 3/19/25, indicated R147 was recently admitted and required care after back surgery. R147's face sheet indicated R147 was full code.	F 578		

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F 578	Continued From page 5 R147's POLST dated 3/9/25, indicated R147 was DNR with selective treatments. R147's admission assessment dated 3/10/25, indicated R147 was alert and orientated. R147's admission assessment further indicated R147's hospital orders indicated DNR/DNI, the code status on the admission POLST was DNR/DNI and the code status matched the code status on the admission POLST. R147's provider order dated 3/11/25, indicated R147 was a full code. R147's care plan initiated 3/10/25, indicated R147 had completed a POLST and was full code. Staff were directed to see orders for current resuscitation order. When interviewed on 3/17/25 at 5:43 p.m., R147 verified they did not want resuscitation or intubation if they became pulseless or had trouble breathing. R147 would let their family determine any other non-invasive treatments. When interviewed on 3/17/25 at 6:40 p.m., RN-H stated a resident's code status would be determined by looking in the computer chart or the POLST in the hard chart and would go to whatever was closest. RN-H verified R147's POLST indicated DNR while the provider order in the EMR stated full code. RN-H stated the provider would need to be contacted to clarify which one was correct. However, if RN-H would go with the signed POLST and follow DNR. Facility policy Residents' Rights Regarding Treatment and Advance Directives dated 4/1/22,	F 578		

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F 578	Continued From page 6 indicated the facility would support and facilitate the resident's wishes to "request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive." Facility policy Communication of Code Status dated 4/1/22, indicated a resident had the right to formulate advance directives and the facility would have processes in place to communicate a resident's code status to all who need to know. The policy indicated identification of a resident's wishes to include full code, DNR, DNI (do not intubate), and do not hospitalize would be clearly documented in designated sections of the medical record. "The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record."	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure bowel monitoring for 1 of 1 resident (R33) reviewed for constipation. Findings include:	F 684	1.) Facility collaborated with Hospice concerning Resident R33. R33 started on as needed Senna on 3/20/25. 2.) Ensuring bowel management is required for all residents. Therefore, all residents have the potential to be	4/24/25

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F 684	Continued From page 7 R33's modification of quarterly Minimum Data Set (MDS) dated 12/13/24, indicated moderately impaired cognition and diagnoses of chronic diastolic (congestive) heart failure, benign prostatic hyperplasia with lower urinary tract symtoms, and encounter for palliative care. It further indicated R33 required staff assistance with most activities of daily living (ADL), mobility, had a catheter, and was always continent of bowel. During interview on 3/17/25 at 2:25 p.m. family member (FM)-B stated the facility didn't monitor R33's bowel movements very well. R33's documentation (under the tasks tab) titled bowel movements (BM), for the month of March 2025, indicated R33 did not have a BM from 3/5/25-3/7/25 and from 3/15/25-3/17/25. R33's standing orders dated 2/18/25, indicated the following steps in montioring for constipation: 1. Consider rectal check to determine if impaction is present 2. Encourage 2,000 millilieters (ml) daily fluid intake unless contraindicated 3. Consult nutrition services for dietary recommendations. 4. Give Sennoside 8.6 milligrams (mg) 2 tablets by mouth daily as needed (PRN) for up to 3 days, if no BM by day 3 offer/give Biscodyl suppository 10 mg: rectally once daily as needed for up to 2 days. 5. Reattempt Senna or Biscodyl if no results after 24 hours and notify provider. R33's last bowel and bladder assessment was completed on 12/13/24.	F 684	affected. 3.) The DON reviewed facility policy and procedures. The DON educated licensed nurses regarding bowel management. A whole house audit of all residents was completed on 04/14/25. Discussion findings were addressed immediately, and all actions were completed on 04/14/25. Nocturnal (NOC) shifts to document bowel alerts for residents going on 3 days for each unit. The NOC shift will report the bowel management sheet to the day shift to follow up to initiate standing house protocol for bowel management. 4.) DON or designee to complete audits once weekly for 1 month, then every other week for 1 month. After 2 months the DON or designee will complete a random record audit of at least 10 residents for bowel management tracking. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained.	

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F 684	Continued From page 8 R33's physician's orders lacked an order for a PRN medication related to constipation. R33's progress notes for the month of March 2025 lacked documentation of bowel monitoring including a bowel assessment, administration of PRN's, or notification of the provider and/or hospice. R33's medication and treatment administration records (MAR/TAR) for the month of March 2025, lacked documentation of bowel movements (BM) or that PRN medications had been administered in regards to constipation. During interview on 3/19/25 at 10:30 a.m., nursing assistant (NA)-A stated the nursing assistants were responsible for documenting each bowel movement and the nurses were responsible for checking the charting every 3 days to make sure the resident had a BM. NA-A further stated NA's should let the nurses know if there was something abnormal reagrding the BM but not necessarily every time the resident had one. During interview on 3/19/25 at 10:55 a.m., NA-B stated the NA's were responsible for documenting if a resident had a BM and (each time they had one) and the nurses were able to see their charting. The NA's don't necessarily let the nurses know each time the resident had a BM unless there was a problem. During interview on 3/19/24 at 11:04 a.m., licensed practical nurse (LPN)-A stated if a resident didn't have specific orders for bowel monitoring, then they should follow the standing orders. They should start following the standard	F 684		

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F 684	Continued From page 9 orders on the 3rd day of the resident not having a BM. LPN-A verified R33 had not had a BM from 3/5/25-3/8/25 and from 3/15/25-3/17/25 and the standing order protocol should have been started on the 3rd day of no BM. During interview on 3/20/25 at 8:45 a.m., LPN-B stated if a resident doesn't have specific orders for bowel monitoring then they were expected to follow the standing orders for constipation which would start on day 3 of no BM. During interview on 3/20/25 at 8:49 a.m., the clinical coordinator stated standing orders are built into the system through the electronic medication administration record (e-mar), unless the resident had their own specific orders and there would be a little red alert letting the nurses know the resident had a BM in 3 days. The NA's were responsible for documenting BM's under the tasks in point of care (computer system for NA documentation) and they were also responsible for letting the nurse know if a resident had a BM. The nurses were responsible for checking the charting, and starting the steps on the standing orders protocol on day 3 of a resident not having a BM. The clinical coordinator verified R33 did not have an order for a PRN medication related to constipation and there wasn't any documentation that the provider or Hospice had been notified. It was Important to keep track of BM's because the resident may develop a bowel obstruction, perforated bowl, rectal tears, and pain. She further verified R33 did not have a BM from 3/5/25-3/7/25 and from 3/15/25-3/17/25. During interview on 3/20/25 at 10:09, the director of nursing (DON) stated his expectation regarding bowel monitoring was the standing orders	F 684		

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F 684	Continued From page 10 protocol should be followed (for residents who do not have specific orders for monitoring BM's) starting on day 2 or 3 of the resident not having one. This was important for comfort and ensuring the resident wasn't impacted. The facility's policy regarding Bowel Assessment and Management dated October of 2022, indicated bowel management protocol will be implemented by nursing staff if resident is identified as needing interventions for constipation. A. Bowel Management Tracking tool is reviewed by all shifts. B. Day shift evaluates bowel function that may include -Abdominal Assessment/Evaluation -Implement non-pharmaceutical interventions (prunes, prune juice, exercise, increase fluids) -Administer pharmaceutical intervention, medical doctor (MD) order would supersede policy. -follow current House Standing Orders C. Diarrhea (Loose Stools) -Follow current House Standing Orders	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		4/24/25

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F 689	Continued From page 11 Based on observation, interview and record review the facility failed to ensure recommendations were followed to minimize risk of aspiration for 1 of 1 residents reviewed for nutrition. Findings include: R23's admission Minimum Data Set (MDS) dated 3/4/25, indicated R23 had mild cognitive impairment and diagnoses of Parkinson's disease (illness that effects the nervous system) and dysphagia (trouble swallowing). R23 required set up for meals and had coughing or choking during meals or when swallowing medications. R23's speech therapy (ST) assessment dated 3/3/25, indicated ST recommended R23 to have a soft diet with bite sized food, thin liquids with no straw use. R23's provider order dated 3/3/25, indicated R23 required a soft diet with bite sized food and thin liquids. R23's orders lacked indication R23 should not use a straw. R23's Kardex printed on 3/17/25, lacked indication R23 should not use a straw. R23's care plan revised 3/3/25, indicated R23 was at risk for nutritional and hydration deficit related to Parkinson's Disease and dysphagia. Interventions directed staff to set up meals and ensure modified diet and thin liquids were provided. R23's care plan lacked indication R23 should not use straws.	F 689	1.) Resident R23 was discharged from the facility on 03/31/25. 2.) Preventing choking hazards related to straws is required for all residents assessed by Speech Language Pathologist (SLP) and recommended to not use straws. Residents who admit from the hospital or from the community with no straw orders are also at risk of being affected by the deficient practice. 3.) DON reviewed facility policies and procedures. DON educated all nursing staff and SLP of new facility protocol. Facility implemented a picture door marker system to help staff identify residents who should not have straws. Facility also implemented a communication email chain between SLP and management to disseminate/document residents not recommended for straw use. Finally, facility implemented the use of Special Instructions under the Care Profile functionality of PCC to signify to nursing staff which residents should not have straws. Facility identified like residents and completed the new procedure tasks on 04/14/25. 4.) DON or designee to complete audits once weekly for 1 month then every other week for 1 month. After 2 months the DON or designee will review all residents not recommended to have straws to ensure plan of correction (POC) compliance. Results of the audits will be discussed with the monthly QAA committee until such time is determined that substantial compliance is maintained.	

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F 689	Continued From page 12 During an observation on 3/17/25 at 12:35 p.m., R23 was seated at the bedside with her lunch tray in front of her. R23 had a large pink water mug with a straw in place. There was also a carton of boost on the bedside table with a straw. On R23's wall was a sign indicating R23 required a soft diet with bite sized pieces, thin liquids and no straw. R23 stated they likes the straws and it was ok to drink without them. When interviewed on 3/17/25 at 12:40 p.m., family member (FM-A) stated R23 had trouble swallowing pills and sometimes coughed after drinking and eating. FM-A stated the staff feel she had a problem swallowing and placed on the soft diet with no straws and R23 had a swallow study scheduled for next week. FM-A further stated R23 had been drinking with the straws today and seemed ok and verified the water and boost were on the bedside table when they arrived. An observation on 3/17/25 at 5:16 p.m., R23 was seated in their wheelchair with dinner on the bedside table. On the bedside table was a large pink mug with water and a straw. An observation on 3/19/25 at 8:24 a.m., R23 was in bed sleeping. Upon the bedside table was a container of boost with a straw in place. At 8:42 a.m., the Social Service Director (SSD) brought in R23 breakfast tray. SSD verified the empty boost container with a straw and stated yesterday, R23 refused to have straws taken away when found in her room. When interviewed on 3/19/25 at 8:51 a.m., registered nurse (RN)-E stated R23 initially had problems with choking when taking pills and	F 689		

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F 689	Continued From page 13 swallowing and wasn't aware of any issues with swallowing lately. RN-E further stated for a time, R23 was not supposed to use straws, however since there were not any issues, R23 could use them. RN-E stated recommendations from ST would be found in the care plan. When interviewed on 3/19/25 at 2:03 p.m., RN-C stated ST would place an assessment and recommendations into the electronic medical record (EMR). The ST placed any diet orders, and nursing would update the care plan. RN-C knew about the change and was not sure how updating the care plan was missed. RN-C stated staff should document if R23 had refused straws to be removed and was aware of R23 refusing to have them removed the day prior. however, RN-C verified there was no other documentation indicating R23 refused to have the straws removed. When interviewed on 3/20/25 at 10:56 a.m., ST stated any recommendations were completed as assessment notes on the EMR. ST further stated if residents were ok with signs in their rooms, those were placed as reminders as well. ST stated R23 was having a formal swallow study next week and could not say if they were at risk for aspiration however when initially assessed R23 was consistently coughing and therefore the diet changed, and direction given for no straw use. ST had been notified on 3/18/25, R23 had refused straws to be taken from her drinks. ST worked with R23 and had R23 drink with a straw and R23 started coughing immediately after. ST re-educated R23 and R23 was agreeable to have the straws removed. ST further stated R23 had cognition impairments and required frequent reminders and education. A new assessment	F 689		

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F 689	Continued From page 14 had not been completed as ST did not have any new recommendations. When interviewed on 3/20/25 at 11:08 a.m., the Director of Nursing (DON) expected recommendations to be communicated on the care plan and for staff to be following the recommendations. DON further stated if residents refused the recommendations, staff should document and inform ST. ST would complete the re-education and document risk/benefits. A facility policy titled Care Plan Revisions Upon Status Changes revised 10/2023, directed staff to review and revise the comprehensive care plan with resident change. Staff who work directly with the resident will report the resident response to the new interventions.	F 689		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		4/24/25

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F 803	Continued From page 15 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure meal choices were provided as ordered for 1 of 2 (R147) residents reviewed for choices. Findings include: R147's face sheet printed 3/19/25, indicated R147 was recently admitted and required care after back surgery. R147's admission assessment dated 3/10/25, indicated R147 was alert and orientated and had a spinal fusion. R147's provider order dated 3/9/25, indicated R147 required a regular diet with thin liquids. R147's care plan initiated 3/10/25, indicated R147 had a nutrition/hydration risk related to spinal fusion and irritable bowel syndrome (condition that can cause bloating, constipation or diahhrea and can be managed by diet). Interventions included to follow diet as ordered. A facility document titled Always Available Menu no date, indicated seasonal fresh fruit was always	F 803	1.) R147 discharged from the facility on 3/28/25. 2.) Meal accuracy is required for all residents. Therefore, all residents have the potential to be affected. 3.) Dietary Director (DD) or designee reviewed facility policy and procedures which remain current. DD provided in service education to all meal delivery staff to ensure meal items ordered by residents are accurate per the resident□s meal ticket. 4.) DD or designee will complete 10 meal accuracy audits weekly for 2 weeks, then 5 meal accuracy audits weekly for 4 weeks thereafter. Results of the audits will be discussed at the monthly QAA committee meeting to ensure compliance.	

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F 803	Continued From page 16	F 803		

available as a side.

R147's meal ticket dated 3/18/25, indicated R147 had ordered a plain hamburger, ketchup and fresh fruit for lunch. R147's meal ticket also indicated R147 had intolerances to lactose, garlic, onion and peppers. R147 also avoids whole wheat.

When interviewed on 3/17/25 at 11:49 a.m., R147 stated she had IBS and many foods bothered her stomach. R147 was frustrated as sometimes what was ordered was forgotten and a few times the meal was completely different than what was ordered. R147 thought it may be someone else's food. R147 stated her family brought in some "if all else fails" food to make sure she had enough options. At 11:50 a.m., dietary aide (DA)-A entered to obtain orders for tomorrow's meals. For lunch, R147 ordered a plain burger with no toppings, ketchup and fresh fruit.

An observation on 3/18/25 at 11:49 a.m., R147 was sitting in a chair with their tray table in front of them. R147 had a plain hamburger with ketchup for lunch. R147 did not have fresh fruit. R147 acknowledged she had not received any fruit. At 12:44 p.m., registered nurse (RN)-C verified there was no fresh fruit delivered to R147.

When interviewed on 3/18/25 at 12:47 p.m., dietary aide (DA)-B stated a resident's meal was checked three times for accuracy. Once when being plated in the kitchen, once before bringing into the room, and once when setting it up with the resident. DA-B had not recalled anything missing for resident's trays served and stated there were lots of trays to deliver. DA-B further stated if someone had ordered fresh fruit, there

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F 803	Continued From page 17 may not have been any left. DA-B stated fruit was cut by one person in the mornings and that was on the breakfast menu this morning and sometimes it gets used up. DA-B stated it doesn't happen often, but has occurred. When interviewed on 3/19/25 at 12:18 p.m., the Dietary Director (DD) stated fresh fruit was always available and stated there was not a shortage yesterday. DD further stated the process was not perfect, and sometimes items may be missed. A facility policy titled Resident Rights dated 10/2022, directed staff to ensure the residents right to make choices about aspects of their care that are significant to the resident.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		4/24/25

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F 812	Continued From page 18 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure facial hair was covered when plating food for delivery and failed to ensure dishwasher temperatures were maintained at required temperatures needed for proper sanitization. Furthermore, the facility failed to ensure refrigerated items were removed after expiration from 1 of 2 unit kitchens reviewed. This had the potential to impact all residents who reside in the facility. Findings include: Facial hair An observation on 3/19/25 at 11:45 a.m., cook-A and cook-B were observed in the main kitchen plating food onto plates for delivery. Cook-A and cook-B both had facial hair and with no beard covers. Cook-A and cook-B both placed food items from the steam table and the grill onto plates before placing them under a heat lamp for other dietary staff to put on trays for delivery. When interviewed on 3/19/25 at 12:03 p.m., cook-A and cook-B verified they did not have beard guards in place. Cook-A stated they were worn only when they were told by leadership to wear them. Cook-B stated he thought the facility did not have any available right now. Unit kitchen An observation on 3/18/25 at 2:41 p.m., the second-floor unit kitchen was reviewed. There were two refrigerators containing snacks and nutritional supplements. Both fridges contained 5 individual containers of Vital Cuisine vanilla mildly	F 812	1.) Kitchen ordered beard covers and implemented their use on 04/15/25. Performed a sweep on all unit kitchens for out-of-date items on 04/15/25. Ecolab verified via testing dishwasher unit on first floor unit kitchen on 3/20/25, results indicated dishwasher is reaching correct temperature above 180 degrees. 2.) Those at risk for the deficient practice identified are staff with facial hair working in kitchen, unit kitchens that store food/supplements, and all dishwashers. 3.) Education provided by DD or designee pertaining to wearing beard guards for staff with facial hair, identifying and removing expired items, and verifying safe temperatures for dishwashers. 4.) DD or designee will complete audits to ensure beard guards are in place, supplements located in the unit kitchens are within expiration date, and dishwashers are maintaining targeted safe temperatures. Audits for beard guards and dishwasher temperatures will be completed 3 times weekly for 2 weeks, then 2 times weekly for 4 weeks thereafter. Audits for unit kitchens will be completed once monthly for 3 months.	

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F 812	Continued From page 19 thick supplements. The best before date was 12/17/24 for all of them. At 3:21 p.m., registered nurse verified the supplements and threw them away. Dishwasher A facility document titled Dish machine Temperature Record (high temperature machine) dated 3/2025, indicated temperatures were taken with each meal. The document directed staff to stop using the machine if the final rinse temperature was less than 180 degrees Fahrenheit (F). 36 out of 58 opportunities (62%) of the recorded rinse temperatures were 180 degrees F or above. An observation on 3/19/25 at 1:38 p.m., dietary aide (DA)-C was observed starting dishes on the 1st floor unit kitchen. The dishwasher was Ecolab dishwasher and DA-C verified it used hot water to sanitize the dishes. A rack of plates was placed in the dishwasher and the final rinse temperature reached 176 degrees F. DA-C took the rack out and proceeded to load another rack of plates and cups. The dishwasher final rinse was 179 degrees F. DA-C verified the temperatures and stated temperatures were tracked for each mealtime. DA-C was not sure what the temperatures needed to get to and stated the temperatures were just written down and then the dishes washed. DA-C reviewed the temperature log for 3/2025 and noted what the wash and rinse temperatures should be. DA-C verified there were shifts documented below 180 degrees F. for rinse tempratures. DA-C stated there had not been any communication with the Dietary Director (DD) about the temperatures documented for 3/19/25.	F 812		

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F 812	Continued From page 20 When interviewed on 3/19/25 at 12:18 p.m., the DD stated kitchen staff were responsible for the snacks and juices on the unit kitchens. Nursing staff ordered the supplements and were responsible to ensure they were stored properly and not outdated. DD further stated beard guards had not been required before but understood food should be protected. In a follow up interview on 3/20/25 at 10:16 a.m., the DD stated they were not of the dishwasher running below normal temperatures. DD felt it was education needed with staff and the dishwasher on the 1st floor was only ran a few times a day and wasn't ran enough to get to the temperatures. DD expected staff to notify him to troubleshoot or call Ecolab. A facility policy titled Ware washing dated 11/3/2023, directed staff to turn on the machine and fill water at the start of the shift and to run the machine and record the temperatures. For a high temperature machine, the wash cycle should be 150-165 degrees F and the rinse cycle 180 degrees F. A facility policy titled Food Storage dated 11/3/22, directed staff to ensure safe food storage to prevent contamination and the spread of illness.	F 812		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(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:	F 881		4/24/25

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 _____	C 03/20/2025

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F 881	Continued From page 21 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure monitoring was in place for 1 of 1 resident (R9) reviewed who had an urinary tract infection (UTI). Finding include: R9's admission Minimum Data Set (MDS) dated 2/27/25, indicated R9 was cognitively intact and had diagnoses of lung failure. R9 was occasionally incontinent of bowel and bladder. R9's provider progress note dated 3/4/25, indicated R9 was having urine frequency, and a UA/UC would be checked. R9's laboratory result report dated 3/5/25, indicated R9's urinary analysis/urinary culture (UA/UC) was positive and indicated R9 had a UTI. R9's provider order dated 3/6/25, indicated R9 required 1gram (gm) ceftriaxone (antibiotic) intermuscular injection once for UTI. R9's orders lacked indication R9 was monitored during symptoms or for the effectiveness of the antibiotic. R9's laboratory result report dated 3/16/25 indicated R9's UA/UC was positive and indicated R9 had a UTI. R9's provider progress note dated 3/17/25,	F 881	1.) R9 discharged from the facility on 3/19/25. 2.) Antibiotic Stewardship and Infection Monitoring is required for all residents starting an antibiotic or those suspected of an infection. Therefore, all residents starting antibiotics or experiencing signs and symptoms of infection are at risk for the deficient practice. 3.) DON and Infection Preventionist (IP) reviewed facilities policies and procedures. The whole house sweep completed 04/14/25. Education to all licensed nurses regarding antibiotic stewardship and infection monitoring provided. Staff nurses/management to identify and review new signs and symptoms of infection and residents who start on a new antibiotic. Residents identified will receive new orders for infection/antibiotic monitoring that will be completed by the floor nursing staff. 4.) IP or designee to complete audits once weekly for 1 month, then every other week for 1 month. After 2 months the IP or designee will review 5 residents who started on antibiotics have had proper tracking completed and that facility remains in compliance. Results of audits will be reported to the monthly QAA committee until such time is determined that substantial compliance is maintained.	

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F 881	Continued From page 22	F 881		

indicated R9 was still having urine frequency and had completed antibiotics for UTI. Repeat UA/UC still showing infection and antibiotic was ordered again.

R9's provider order dated 3/17/25, indicated R9 required 1gm ceftriaxone intermuscular injection once for UTI. R9's orders lacked indication R9 was monitored during symptoms or for the effectiveness of the antibiotic.

A review of R9's nursing progress notes dated 3/5/25 through 3/19/25, lacked indication R9 was monitored for symptoms of UTI or effectiveness of the antibiotic.

A facility document titled antibiotic tracking dated 3/2025, indicated R9 had received ceftriaxone on 3/5/25, for a UTI with symptoms of burning and urgency. The column titled symptoms resolved was blank. The document further indicated R9 had received ceftriaxone on 3/17/25, for UTI with the same symptoms of burning and urgency.

When interviewed on 3/17/25 at 3:28 p.m., R9 stated had a UTI. R9 stated the provider ordered a second round of antibiotics but had not received any yet. R9 stated it hurts to urinate and she needed to go about every 30 minutes or so.

When interviewed on 3/18/25 at 2:26 p.m., nursing assistant (NA)- C stated R9 was having to use the bathroom frequently for a while. NA-C further stated R9 had a UTI and did get antibiotics for treatment.

When interviewed on 3/18/25 at 3:05 p.m., registered nurse (RN)-F stated when a resident had symptoms of an infection an assessment

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F 881	Continued From page 23 would be completed and the provider notified. If labs were ordered, make sure those were collected. RN-E stated there was usually an order to monitor for symptoms or an infection note was placed. RN-E verified R9 was treated twice for UTI and knows symptoms included feeling a need to urinate urgently. RN-E wasn't sure of symptoms with the current UTI. RN-E verified there was no documentation of R9's symptoms to determine the effectiveness of the antibiotics. When interviewed on 3/20/25 at 10:17 a.m., the infection preventionist (IP) stated R9 had complained of frequency to the provider and then the provider ordered the UA/UC. IP expected floor nurses to be monitoring and documenting symptoms while on the antibiotic, even if it was a one time shot. IP further stated there were orders that should be placed to ensure monitoring of symptoms and temperature was completed. When interviewed on 3/20/25 at 11:18 a.m., the Director of Nursing (DON) expected staff to staff to be monitoring residents for probable or confirmed infections. DON stated there were batch orders that should have been placed to ensue the monitoring was occurring each shift. This was important to ensure residents improve or stabilize. A facility policy titled Antibiotic Stewardship revised 5/2023, directed nursing staff to assess residents who are suspected to have an infection and notify the provider and monitor response to antibiotics to determine if adjustments should be made.	F 881		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 7, 2025

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: State Nursing Home Licensing Orders
Event ID: CNRH11

Dear Administrator:

The above facility was surveyed on March 17, 2025 through March 20, 2025 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 03/20/2025

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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: On 3/17/25 through 3/20/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H56329981C/MN111310, H56329281C/MN104425, H56329263C/MN107876. No citations were issued. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
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 record review the facility failed to ensure facial hair was covered when plating food for delivery and failed to ensure dishwasher temperatures were maintained at required temperatures needed for proper sanitization. Furthermore, the facility failed to ensure refrigerated items were removed after expiration from 1 of 2 unit kitchens reviewed. This had the potential to impact all residents who reside in the facility. Findings include: Facial hair An observation on 3/19/25 at 11:45 a.m., cook-A and cook-B were observed in the main kitchen plating food onto plates for delivery. Cook-A and cook-B both had facial hair and with no beard	21015	1.) Kitchen ordered beard covers and implemented their use on 04/15/25. Performed a sweep on all unit kitchens for out-of-date items on 04/15/25. Ecolab verified via testing dishwasher unit on first floor unit kitchen on 3/20/25, results indicated dishwasher is reaching correct temperature above 180 degrees. 2.) Those at risk for the deficient practice identified are staff with facial hair working in kitchen, unit kitchens that store food/supplements, and all dishwashers. 3.) Education provided by DD or designee pertaining to wearing beard guards for staff with facial hair, identifying and removing expired items, and verifying safe temperatures for dishwashers. 4.) DD or designee will complete audits to	4/24/25

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21015	Continued From page 3 covers. Cook-A and cook-B both placed food items from the steam table and the grill onto plates before placing them under a heat lamp for other dietary staff to put on trays for delivery. When interviewed on 3/19/25 at 12:03 p.m., cook-A and cook-B verified they did not have beard guards in place. Cook-A stated they were worn only when they were told by leadership to wear them. Cook-B stated he thought the facility did not have any available right now. Unit kitchen An observation on 3/18/25 at 2:41 p.m., the second-floor unit kitchen was reviewed. There were two refrigerators containing snacks and nutritional supplements. Both fridges contained 5 individual containers of Vital Cuisine vanilla mildly thick supplements. The best before date was 12/17/24 for all of them. At 3:21 p.m., registered nurse verified the supplements and threw them away. Dishwasher A facility document titled Dish machine Temperature Record (high temperature machine) dated 3/2025, indicated temperatures were taken with each meal. The document directed staff to stop using the machine if the final rinse temperature was less than 180 degrees Fahrenheit (F). 36 out of 58 opportunities (62%) of the recorded rinse temperatures were 180 degrees F or above. An observation on 3/19/25 at 1:38 p.m., dietary aide (DA)-C was observed starting dishes on the 1st floor unit kitchen. The dishwasher was Ecolab dishwasher and DA-C verified it used hot water to sanitize the dishes. A rack of plates was	21015	ensure beard guards are in place, supplements located in the unit kitchens are within expiration date, and dishwashers are maintaining targeted safe temperatures. Audits for beard guards and dishwasher temperatures will be completed 3 times weekly for 2 weeks, then 2 times weekly for 4 weeks thereafter. Audits for unit kitchens will be completed once monthly for 3 months.	

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21015	Continued From page 4 placed in the dishwasher and the final rinse temperature reached 176 degrees F. DA-C took the rack out and proceeded to load another rack of plates and cups. The dishwasher final rinse was 179 degrees F. DA-C verified the temperatures and stated temperatures were tracked for each mealtime. DA-C was not sure what the temperatures needed to get to and stated the temperatures were just written down and then the dishes washed. DA-C reviewed the temperature log for 3/2025 and noted what the wash and rinse temperatures should be. DA-C verified there were shifts documented below 180 degrees F. for rinse tempratures. DA-C stated there had not been any communication with the Dietary Director (DD) about the temperatures documented for 3/19/25. When interviewed on 3/19/25 at 12:18 p.m., the DD stated kitchen staff were responsible for the snacks and juices on the unit kitchens. Nursing staff ordered the supplements and were responsible to ensure they were stored properly and not outdated. DD further stated beard guards had not been required before but understood food should be protected. In a follow up interview on 3/20/25 at 10:16 a.m., the DD stated they were not of the dishwasher running below normal temperatures. DD felt it was education needed with staff and the dishwasher on the 1st floor was only ran a few times a day and wasn't ran enough to get to the temperatures. DD expected staff to notify him to troubleshoot or call Ecolab. A facility policy titled Ware washing dated 11/3/2023, directed staff to turn on the machine and fill water at the start of the shift and to run the machine and record the temperatures. For a high	21015		

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21015	Continued From page 5 temperature machine, the wash cycle should be 150-165 degrees F and the rinse cycle 180 degrees F. A facility policy titled Food Storage dated 11/3/22, directed staff to ensure safe food storage to prevent contamination and the spread of illness. SUGGESTED METHOD OF CORRECTION: The dietary manager or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures were monitored per manufacturer's guidelines, ensure proper hair protection was worn for facial hair, and could educate all appropriate staff on the policies and procedures; and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure monitoring was in place for 1 of 1 resident (R9) reviewed who had an urinary tract infection (UTI).	21385	1.) R9 discharged from the facility on 3/19/25. 2.) Antibiotic Stewardship and Infection Monitoring is required for all residents starting an antibiotic or those suspected of	4/24/25

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21385	Continued From page 6 Finding include: R9's admission Minimum Data Set (MDS) dated 2/27/25, indicated R9 was cognitively intact and had diagnoses of lung failure. R9 was occasionally incontinent of bowel and bladder. R9's provider progress note dated 3/4/25, indicated R9 was having urine frequency, and a UA/UC would be checked. R9's laboratory result report dated 3/5/25, indicated R9's urinary analysis/urinary culture (UA/UC) was positive and indicated R9 had a UTI. R9's provider order dated 3/6/25, indicated R9 required 1gram (gm) ceftriaxone (antibiotic) intermuscular injection once for UTI. R9's orders lacked indication R9 was monitored during symptoms or for the effectiveness of the antibiotic. R9's laboratory result report dated 3/16/25 indicated R9's UA/UC was positive and indicated R9 had a UTI. R9's provider progress note dated 3/17/25, indicated R9 was still having urine frequency and had completed antibiotics for UTI. Repeat UA/UC still showing infection and antibiotic was ordered again. R9's provider order dated 3/17/25, indicated R9 required 1gm ceftriaxone intermuscular injection once for UTI. R9's orders lacked indication R9 was monitored during symptoms or for the effectiveness of the antibiotic. A review of R9's nursing progress notes dated	21385	an infection. Therefore, all residents starting antibiotics or experiencing signs and symptoms of infection are at risk for the deficient practice. 3.) DON and Infection Preventionist (IP) reviewed facilities policies and procedures. The whole house sweep completed 04/14/25. Education to all licensed nurses regarding antibiotic stewardship and infection monitoring provided. Staff nurses/management to identify and review new signs and symptoms of infection and residents who start on a new antibiotic. Residents identified will receive new orders for infection/antibiotic monitoring that will be completed by the floor nursing staff. 4.) IP or designee to complete audits once weekly for 1 month, then every other week for 1 month. After 2 months the IP or designee will review 5 residents who started on antibiotics have had proper tracking completed and that facility remains in compliance. Results of audits will be reported to the monthly QAA committee until such time is determined that substantial compliance is maintained.	

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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) COMPLETE DATE
21385	Continued From page 7 3/5/25 through 3/19/25, lacked indication R9 was monitored for symptoms of UTI or effectiveness of the antibiotic. A facility document titled antibiotic tracking dated 3/2025, indicated R9 had received ceftriaxone on 3/5/25, for a UTI with symptoms of burning and urgency. The column titled symptoms resolved was blank. The document further indicated R9 had received ceftriaxone on 3/17/25, for UTI with the same symptoms of burning and urgency. When interviewed on 3/17/25 at 3:28 p.m., R9 stated had a UTI. R9 stated the provider ordered a second round of antibiotics but had not received any yet. R9 stated it hurts to urinate and she needed to go about every 30 minutes or so. When interviewed on 3/18/25 at 2:26 p.m., nursing assistant (NA)- C stated R9 was having to use the bathroom frequently for a while. NA-C further stated R9 had a UTI and did get antibiotics for treatment. When interviewed on 3/18/25 at 3:05 p.m., registered nurse (RN)-F stated when a resident had symptoms of an infection an assessment would be completed and the provider notified. If labs were ordered, make sure those were collected. RN-E stated there was usually an order to monitor for symptoms or an infection note was placed. RN-E verified R9 was treated twice for UTI and knows symptoms included feeling a need to urinate urgently. RN-E wasn't sure of symptoms with the current UTI. RN-E verified there was no documentation of R9's symptoms to determine the effectiveness of the antibiotics. When interviewed on 3/20/25 at 10:17 a.m., the	21385		

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	31025	A. BUILDING: _____ B. WING _____	C 03/20/2025

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21385	Continued From page 8 infection preventionist (IP) stated R9 had complained of frequency to the provider and then the provider ordered the UA/UC. IP expected floor nurses to be monitoring and documenting symptoms while on the antibiotic, even if it was a one time shot. IP further stated there were orders that should be placed to ensure monitoring of symptoms and temperature was completed. When interviewed on 3/20/25 at 11:18 a.m., the Director of Nursing (DON) expected staff to staff to be monitoring residents for probable or confirmed infections. DON stated there were batch orders that should have been placed to ensue the monitoring was occurring each shift. This was important to ensure residents improve or stabilize. A facility policy titled Antibiotic Stewardship revised 5/2023, directed nursing staff to assess residents who are suspected to have an infection and notify the provider and monitor response to antibiotics to determine if adjustments should be made. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise the antibiotic stweardship policy and procedures. The DON or designee could re-educate nursing staff on antibiotic stewardship policey and procedures. The DON or designee could complete an audit on staff implementing antibiotic policy/procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

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21840	Continued From page 9	21840		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 2 residents (R147, R198) reviewed for Physician Orders for Life Sustaining Treatment (POLST) had the correct code status (i.e. full code, do not resuscitate-DNR) information outlined within the medical record. This could cause R147 and R198 to receive resuscitation efforts (i.e. cardiopulmonary resuscitation-CPR) against their wishes. Findings include: R198 R198's 5-day Minimum Data Set (MDS) dated 3/18/25, indicated R198 was cognitively intact. R198's diagnoses included osteoarthritis of right shoulder, congestive heart failure, chronic kidney	21840	1.) Resident R147 discharged from the facility on 3/28/25 and R198 discharged from facility on 03/19/25 2.) Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected. 3.) The Director of Nursing (DON) educated licensed nurses regarding the documentation procedures for Advance Directives/Code Status. A chart audit of all residents was completed on 04/14/25. Discrepant findings were addressed immediately, and all actions were completed on 04/14/25. DON reviewed facility policies and procedures which remain current. 4.) DON or designee to complete audits to be completed on all TCU admissions	4/24/25

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21840	Continued From page 10 disease, and hypertension. R198's face sheet printed 3/17/25 at 7:50 p.m., indicated R198's advance directive listed full code. R198's admission assessment dated 3/12/25, indicated, "Code Status ON HOSPITAL ORDERS: Full Code/CPR...Code Status ON ADMISSION POLST: DNR/DNI...Does the code status on the hospital orders MATCH the code status on the admission POLST orders?: No." The admission assessment indicated in bold, red print, "Code status on hospital order DOES NOT match admission POLST orders!!! Nurse must call provider immediately and get a verbal order confirmation of code status." R198's care plan printed 3/17/25, indicated, "POLST: Resident has completed a POLST: Full code ...Resident wishes will be followed and respected ...See Orders for current Resuscitation order." R198's physician orders dated 3/13/25, indicated, "Full Code ...Active." R198's POLST signed by R198 3/12/25, indicated, "Do Not Attempt Resuscitation/DNR [Allow Natural Death] ...Comfort Focused Treatment." During interview on 3/17/25 at 6:45 p.m., R198 stated would not want CPR, "no pounding on my chest" if found unresponsive and without a heartbeat. R198 stated would not want any tubes or other artificial means to be kept alive. During interview on 3/17/25 at 6:59 p.m., registered nurse (RN)-A stated the POLST could	21840	once weekly for 1 month, then every other week for 1 month. After 2 months the DON or designee will complete a random record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained.	

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21840	Continued From page 11 be found in the hard chart and code status could also be seen in the electronic medical record (EMR). RN-A stated the EMR should match the POLST. During interview on 3/17/25 at 7:04 p.m., RN-B stated I would look in the hard chart for the POLST and the code status would also be in the computer. RN-B stated the hard chart should match the EMR, but sometimes the EMR was not updated. During interview on 3/17/25 at 7:39 p.m., RN-A stated R198 was a DNR/DNI according to the POLST located in R198's hard chart. RN-A then looked in R198's EMR and verified R198's face sheet indicated R198 was full code. RN-A stated if a nurse were to look in the computer first, they would think R198 wanted full resuscitation which was against her wishes. During interview on 3/17/25 at 7:49 p.m., RN-C stated the EMR should match the POLST which should reflect the resident's wishes. RN-C stated if the EMR indicated a resident was full code and the POLST indicated DNR, it could be possible the resident would receive resuscitation efforts when they really wanted DNR. During interview on 3/18/25 at 11:03 a.m., RN-D stated upon admission the nurse would complete an assessment on the resident which included current code status. RN-D stated part of the assessment was to determine what the hospital had documented as code status which would be their admission code status and determine if that was still accurate. The admission assessment worksheet in the EMR would indicate a warning in red when the resident's current code status wish did not match the admission order code status.	21840		

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21840	Continued From page 12 The warning instructed the nurse to contact the provider immediately to update the order to match the resident's wishes. RN-D stated it was important to have the POLST and EMR to match and also to reflect the resident's current code status wishes. During interview on 3/18/25 at 1:01 p.m., director of nursing (DON) stated expectation for admission nurse to complete a new POLST on every resident and confirm the EMR accurately reflected the POLST which would reflect the resident's accurate code status wishes. DON stated expectation for the code status to be updated timely and be accurate throughout the resident's EMR and hard chart. R147 R147's face sheet printed 3/19/25, indicated R147 was recently admitted and required care after back surgery. R147's face sheet indicated R147 was full code. R147's POLST dated 3/9/25, indicated R147 was DNR with selective treatments. R147's admission assessment dated 3/10/25, indicated R147 was alert and orientated. R147's admission assessment further indicated R147's hospital orders indicated DNR/DNI, the code status on the admission POLST was DNR/DNI and the code status matched the code status on the admission POLST. R147's provider order dated 3/11/25, indicated R147 was a full code. R147's care plan initiated 3/10/25, indicated R147 had completed a POLST and was full code. Staff	21840		

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21840	Continued From page 13 were directed to see orders for current resuscitation order. When interviewed on 3/17/25 at 5:43 p.m., R147 verified they did not want resuscitation or intubation if they became pulseless or had trouble breathing. R147 would let their family determine any other non-invasive treatments. When interviewed on 3/17/25 at 6:40 p.m., RN-H stated a resident's code status would be determined by looking in the computer chart or the POLST in the hard chart and would go to whatever was closest. RN-H verified R147's POLST indicated DNR while the provider order in the EMR stated full code. RN-H stated the provider would need to be contacted to clarify which one was correct. However, if RN-H would go with the signed POLST and follow DNR. Facility policy Residents' Rights Regarding Treatment and Advance Directives dated 4/1/22, indicated the facility would support and facilitate the resident's wishes to "request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive." Facility policy Communication of Code Status dated 4/1/22, indicated a resident had the right to formulate advance directives and the facility would have processes in place to communicate a resident's code status to all who need to know. The policy indicated identification of a resident's wishes to include full code, DNR, DNI (do not intubate), and do not hospitalize would be clearly documented in designated sections of the medical record. "The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record."	21840		

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21840	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records a re consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON should also ensure a process for inputting this changed data appropriately into the electronic medical record. Staff should be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident EMR. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21840		

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	245632	A. BUILDING **01 - ST THERESE OF WOODURY** B. WING _____	**03/18/2025**

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K 000	INITIAL COMMENTS Initial Comments Section FIRE SAFETY An annual Life Safety Code survey was conducted on 03/18/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Therese of Woodbury was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: ST THERESE OF WOODBURY is a 2-story building with a full basement. The original building was built in 2016 and was determined to be of Type II (111) construction. The facility has 2-hour fire separation between the nursing home and the assisted living portions of the structure	K 000		

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K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		4/24/25

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K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 03/18/2025 between 10:00AM and 12:00 PM, it was revealed by observation the door to the soiled utility room on the second floor in the Hawthorne wing did not latch when testing the self-closing device. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 321	1. The door for the soiled utility room on the Hawthorn unit has been adjusted to latch with the self-closing device. 2. All doors with a self-closing device that lead into a hazardous room have the potential of not latching. 3. The Plant Operation Director/designee inspected all doors leading to a hazardous room to ensure they latch with the self-closing device. 4. All doors leading into a hazardous room will be audited twice weekly for 4 weeks and monthly thereafter for 3 months by the Plant Operation Director/designee. The audits will be reviewed at the monthly QAA Committee meeting to ensure compliance.	
K 930 SS=F	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 930		4/24/25

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K 930	Continued From page 4 Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/18/2025 between 10:00 AM and 12:00 PM, it was revealed by observation that there were multiple liquid oxygen containers being stored on the second floor near the nurses station in the Hawthorne wing. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 930	1. The liquid oxygen containers on the Hawthorn unit near the nurse□s station have been properly stored in the Oxygen storage room. 2. All areas have the potential of having liquid oxygen containers being stored unsafely. 3. Nursing and housekeeping staff will be re-educated on the proper storage of liquid oxygen containers by the DON/designee. 4. Audits will be completed by the Healthcare Administrator/designee twice weekly for 4 weeks and monthly thereafter for 3 months to ensure liquid oxygen containers are stored properly. The audits will be reviewed at the monthly QAA Committee meeting to ensure compliance.	