#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TI						ID: JJFL
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00261
1. MEDICARE/MEDICAID PROVIDER N (L1) 245518	Э.	3. NAME AND ADI (L3) ST THERESI	E HOME	Ϋ́		<ul> <li>4. TYPE OF ACTION: <u>7 (</u>L8)</li> <li>1. Initial 2. Recertification</li> </ul>
2.STATE VENDOR OR MEDICAID NO. (L2) <b>712242000</b>		(L4) 8000 BASS L (L5) NEW HOPE,			(L6) <b>55428</b>	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 04/23/		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		06/30
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	00/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:			
From (a):		X A. In Complian	ce With		And/Or Approved Waivers Of The	e Following Requirements:
To (b) :		Program Re Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit
12.Total Facility Beds	<b>258</b> (L18)		cceptable POC		5. 24 Hour KN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>258</b> (L17)		pliance with Program ents and/or Applied V		* Code: <b>A</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
258						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
LoAnn DeGagne,	HFE NE II		03/26/2015	(L19)	Kate JohnsTon, Enf	orcement Specialist 04/23/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAI	L OFFICE OR SINGLE STAT	'E AGENCY
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH CI	IVIL	21. 1. Statement of Financi 2. Ownership/Control I	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
<b>X</b> 1. Facility is Eligible to Part	icipate	KIGH	IISACI.		3. Both of the Above :	interest Disclosure Sunt (HCFA-1515)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING I		ENDING DATE		VOLUNTARY _00	× /
02/01/1988					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension of	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Sus	nension Date:	(L44)			00-Active
	D. Reseniu Susj	pension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	Έ	Posted 05/07/2015 Co.	
	(L32)	04/27/2015		(L33)	DETERMINATION APPRO	VAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245518 April 30, 2015

Ms. Dinah Martin, Administrator St. Therese Home 8000 Bass Lake Road New Hope, Minnesota 55428

Dear Ms. Martin:

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

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

Effective April 4, 2015 the above facility is certified for or recommended for:

258 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 258 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 30, 2015

Ms. Dinah Martin, Administrator St Therese Home 8000 Bass Lake Road New Hope, Minnesota 55428

Re: Reinspection Results - Project Number S5518025

Dear Ms. Martin:

On April 23, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245518	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 4/23/2015
Name of Facility		Street Address, City, State, Zip Code	
ST THERESE HOME		8000 BASS LAKE ROAD NEW HOPE, MN 55428	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

	Correction Completed _04/04/2015
	_04/04/2015 
	-
	_
	Correction
	Completed
	_
	-
	Correction
	Completed
	_
	_
	-
	Correction
	Completed
	_
	-
	-
	Correction
	Completed
	_
	_
Date:	
4/2	3/2015
Date:	
YES	NO
	Date: 4/2 Date:



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 30, 2015

Ms. Dinah Martin, Administrator St Therese Home 8000 Bass Lake Road New Hope, Minnesota 55428

Re: Reinspection Results - Project Number

Dear Ms. Martin:

On April 23, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

#### State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00261	<b>(Y2) Multiple Construction</b> A. Building B. Wing	A. Building	
Name	of Facility		Street Address, City, State, Zip Code	
ST THERESE HOME			8000 BASS LAKE ROAD NEW HOPE, MN 55428	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5	) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5) [	Date
ID Prefix	20435	Correction Completed 03/27/2015	ID Prefix	20965	Correction Completed 03/26/2015	ID Prefix	21530	Correction Completed 04/04/2015
Reg. # LSC	MN Rule 4658.0210 Subp.	2 A.I	-	MN Rule 4658.0600 Subp.		Reg. # LSC	MN Rule 4658.1310 A.B.C	_
1.00	21540 MN Rule 4658.1315 Subp.	_	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
Reg. #		_	Reg. #			Reg. #		
ID Prefix Reg. # LSC		Correction Completed 	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed 
ID Prefix Reg. # LSC		_	ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		_
Reviewed By State Agency Reviewed By CMS RO	<u> </u>	JS/KJ	Date: 04/30/20 Date:	Signature of Surve	32208	8	Date: 4/23 Date:	/2015
Followup to	Survey Completed on: 3/5/2015 1: REVISIT REPORT (3	5/99)	 			Deficiencies. Was (CMS-2567) Sent		NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

TAKI		'E SUDVEV ACENCV	E
I. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245518           2.STATE VENDOR OR MEDICAID NO.           (L2)         712242000	3. NAME AND ADDRESS OF FACILITY (L3) ST THERESE HOME (L4) 8000 BASS LAKE ROAD (L5) NEW HOPE, MN	E SURVEY AGENCY (L6) 55428	Facility ID: 00261       4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>On-Site Visit</li> <li>Other</li> <li>Full Survey After Complaint</li> </ol>
6. DATE OF SURVEY     03/05/2015     (L34)       8. ACCREDITATION STATUS:	02 SNF/NF/Dual         06 PRTF         10 NF           03 SNF/NF/Distinct         07 X-Ray         11 ICF/IID           04 SNF         08 OPT/SP         12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         258 (L18)         13.Total Certified Beds         258 (L17)         14. LTC CERTIFIED BED BREAKDOWN	<ul> <li>10.THE FACILITY IS CERTIFIED AS:</li> <li>A. In Compliance With Program Requirements Compliance Based On:</li> <li>1. Acceptable POC</li> <li>X B. Not in Compliance with Program Requirements and/or Applied Waivers:</li> </ul>	And/Or Approved Waivers Of The. 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: <b>B</b> * 15. FACILITY MEETS	Following Requirements:
18 SNF 18/19 SNF 19 SNF 258 (L37) (L38) (L39)	ICF IID (L42) (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S 17. SURVEYOR SIGNATURE Holly Kranz, HFE NE II	Date :	18. STATE SURVEY AGENCY APP Kate JohnsTon, Enfo	ROVAL Date: Drcement Specialist 04/23/2015 (L20)
PART II - TO 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	BE COMPLETED BY HCFA REGIONAL 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Financia	
22. ORIGINAL DATE 23. LTC AGREEMI OF PARTICIPATION BEGINNING 1 02/01/1988 (L24) (L41)		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATIVI A. Suspension of (L27) B. Rescind Sus	E SANCTIONS of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29	(L45) . INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (L31)		
31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DATE	Posted 04/27/2015 Co.	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 16, 2015

Ms. Dinah Martin, Administrator St. Therese Home 8000 Bass Lake Road New Hope, Minnesota 55428

RE: Project Number S5518025

Dear Ms. Martin:

On March 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

## months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

## DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343 Fax: (320)223-7348

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 14, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved

in your plan of correction.

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

## Original deficiencies not corrected

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

## Original deficiencies not corrected and new deficiencies found during the revisit

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

## Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## **INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions.

Sincerely,

ate Comston

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OME	B NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (X		E SURVEY PLETED
		245518	B. WING			03/0	05/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE HOME				00 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 000	INITIAL COMMENT	S	F 0	00			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 nic submission of the POC will ion of compliance.					
F 247 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with T TO NOTICE BEFORE E CHANGE	F 2	47			3/27/15
		ight to receive notice before or roommate in the facility is					
	by: Based on observat review, the facility fa (R183) reviewed for discharge received new roommates. Findings include: R183's admission M dated 12/24/14, ind cognitive impairment During interview on	NT is not met as evidenced ion, interview, and document ailed to ensure 1 of 1 resident r admission, transfer, and notification prior to receiving Minimum Data Set (MDS) icated the resident had no nt. 3/4/15, at 9:33 a.m. family ted R183 had several new			Resident admitted on 12/18/14 and signed the admission paperwork that included the social service admission information which explained that she admitted to a shared room and due to high demand for placement on the TC she might receive a new roommate th same day that her previous roommate moved out or discharged. On 3/9/15, resident was going to be receiving a r roommate and she was informed of th All TCU residents living in shared roo that would have received a new room-mate could have been affected	was o the CU he the new his. ooms	
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Electronically Signed

(X6) DATE 03/26/2015

PRINTED: 03/26/2015

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.

		(X2) MEILTID			0938-039
OF DEFICIENCIES	IDENTIFICATION NUMBER:				PLETED
	245518	B. WING		03/0	5/2015
PROVIDER OR SUPPLIER					
RESE HOME					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	LD BE	(X5) COMPLETIO DATE
•	-	F 247			
			Social Services revised the pract policy to include notification to T	ice and CU	
room from her adm Transitional care ur	hission on 12/18/14, to the hit (TCU) through 3/15,		the process of documentation. The Room Change and Notifica New Roommate policy has been to reflect the practice of verbally	tion of updated notifying	
reviewed from her a the survey and con indicating R183 wa	admission through the dates of tained no information s informed of any of the 4		new roommate and documenting residents chart. Education on the was completed with social servic 3/10/15. On 3/27/15 a random sa admissions to TCU will have a ch	in the policy e on ample of nart	
was in her room ea and oriented. During interview on stated R183 had se	ting breakfast and was alert 3/05/15, at 8:59 a.m. FM-B everal roommate changes		in the policy are being followed. An observation will be complete time per month for the first three and then quarterly for the following ensure that residents in shared r	ed one months ng year to ooms on	
of them beforehand During interview on stated she had a "L she was admitted t "Just wheel them in	d. 3/05/15, at 9:23 a.m. R183 .ot" of new roommates since o the facility, and staff would " to the room and did not		a new roommate and notification documented in medical record. F from the observations will be pre the facility clinical Quality Improv meeting. Director of Social Servi	indings sented at ement	
into her room. R18 her and stated it wo warning."	3 stated this was disruptive to build be, "Nice to have more				
worker (SW)-A stat TCU were made av Admission Informa frequent roommate not receive advanc	ed residents admitted to the ware on the Social Service tion form there may be changes, so the residents did				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par roommates since h and had not been in into the room. Review of an Admis room from her adm Transitional care un indicated R183 had Review of R183's N reviewed from her a the survey and con indicating R183 wa roommates moving During observation was in her room ea and oriented. During interview on stated R183 had se since admission and of them beforehand During interview on stated she had a "L she was admitted t "Just wheel them ir notify her when a n into her room. R18 her and stated it wo warning." During interview on worker (SW)-A state TCU were made av Admission Informate not receive advance	IDENTIFICATION NUMBER:         245518         PROVIDER OR SUPPLIER         RESE HOME         Continued From page 1         roommates since her admission in December, and had not been informed prior to them moving into the room.         Review of an Admission Report regarding R183's room from her admission on 12/18/14, to the Transitional care unit (TCU) through 3/15, indicated R183 had four different roommates.         Review of R183's Nursing Progress Notes were reviewed from her admission through the dates of the survey and contained no information indicating R183 was informed of any of the 4 roommates moving into her room.         During observation on 3/4/15, at 8:30 a.m. R183 was in her room eating breakfast and was alert and oriented.         During interview on 3/05/15, at 8:59 a.m. FM-B stated R183 had several roommate changes since admission and had not been made aware of them beforehand.         During interview on 3/05/15, at 9:23 a.m. R183 stated she had a "Lot" of new roommates since she was admitted to the facility, and staff would "Just wheel them in" to the room and did not notify her when a new resident was being moved into her room. R183 stated this was disruptive to her and stated it would be, "Nice to have more warning."         During interview on 3/05/15, at 11:05 a.m. social worker (SW)-A stated residents admitted to the TCU were made aware on the Social Service Admission Information form there may be frequent roommate changes, so the residents did not roceive advance notice of a roommate	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245518       B. WING	OF CORRECTION       DENTIFICATION NUMBER:       A. BUILDING         245518       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BESE HOME       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREVENDE       PREVIDER NO BASS LAKE ROAD         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREVIDER ACTION SHOLD         (EACH ODERIGINATION)       PREVIDER SPLAN OF CORRECT       (EACH ODERIGINATION)         Continued From page 1       PREVIDENTIFY ING INFORMATION)       PREVIDENTIFY ING INFORMATION)         Continued From page 1       F 247       This practice. On 3/10/15, Director         roommates since her admission in December, and had not been informed prior to them moving into the room.       F 247       The Room Change and Notifics         Review of an Admission Report regarding R183's room from her admission through 115, indicating R183 had four different roommates.       F 247       The Room Change and Notifics         Review of R183's Nursing Progress Notes were reviewed from her admission through the dates of the survey and contained no information indicating R183 was informed of any of the 4 roommate and documenting residents Shade several roommate changes since admission and had not been made aware of them beforehand.       Stated A18 ad several roommate changes stated A18 ad several roommate changes stated A18 ad several roommate changes stated she had a "Lot" of new roommates since she was admitted to the facility, and statif would "Just wheel them in' to the room an	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       Commonstance         245518       B. WING       33/0         PROVIDER OR SUPPLIER       STREET ADDRESS. CITY, STATE. ZIP CODE       8000 BASS LAKE ROAD         RESE HOME       STREET ADDRESS. CITY, STATE. ZIP CODE       8000 BASS LAKE ROAD         RESE HOME       NEW HOPE, MN 55428       STREET ADDRESS. CITY, STATE. ZIP CODE         Continued From page 1       PROVIDERS PLAN OF CORRECTION       PREFIX         roommates since her admission in December, and had not been informed prior to them moving into the room.       PREFIX       F 247         Review of an Admission Report regarding R183's noom from her admission on 12/18/14, to the Transitional care unit (TCU) through 3/15, indicater R183 had four different roommates.       F 247       The Room Change and Notification of TOU urgeident frequent roommates.         During observation on 3/4/15, at 8:30 a.m. R183 was in her room adting breakfast and was alert and oriented.       ToU resident secients received in the policy to include notification of TCU will have a chart review completed with social service on 3/10/15, at 3:23 a.m. R183 stated She had a "L01" of new roommates since she was admitted to the facility, and staff would rule year being followed.       An observation will be completed at the facility clinical Guality inprovement meeting. Director of Social Services will be resented at the facility clinical Guality inprovement meeting. Director of Social Services will be resented at the facility clinical Guality inprovement meeting. Director of Social Services will be responsible for coo

If continuation sheet Page 2 of 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		<b></b>				
	PROVIDER OR SUPPLIER	245518	B. WING	STREET ADDRESS, CITY, STATE, ZIP		05/2015
	RESE HOME			8000 BASS LAKE ROAD NEW HOPE, MN 55428	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 247 F 325 SS=D	may receive a new previous roommate The facility policy tit indicated the social currently in the roor new roommate.	ent on the TCU, residents roommate the same day the discharges. ded Room Change dated 1/13, worker will notify the resident in that they are receiving a	F 2	325		3/26/15
	resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t	cility must ensure that a stable parameters of nutritional ly weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a				
	by: Based on observat review, the facility fa implement intervent residents, (R219) re Findings include: R219's quarterly Mi 12/11/14, identified cognitive impairment assistance with eati loss, and was not o planned weight loss R219's current phys	NT is not met as evidenced ion, interview, and document ailed to identify, assess, and tions for weight loss for 1 of 3 eviewed for weight loss. nimum Data Set (MDS) dated the resident had server nt, required extensive ing, had no significant weight n a physician prescribed/ s program. sician orders signed 2/5/15, s including psychosis,		The Physician/Nurse Prace notified of the weight loss Significant Change in State (SCSA) was opened. On 3 additional can of Ensure w breakfast as well as an HS cream and a cookie. Nutrit assessments were complet and 3/9/15. A speech thera was obtained on 3/6/15. R changed on 3/9/15 to Mec with thin liquids. On 3/19/1 a hospice intake and spee	on 3/4/15 and a us Assessment, /5/15, an as added to 5 snack of ice ion eted on 3/6/15 apy evaluation esident diet was hanical Soft 5, resident had	

Facility ID: 00261

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						OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRU			E SURVEY PLETED
		245518	B. WING			03/0	05/2015
IAME OF I	PROVIDER OR SUPPLIER	-		STREET ADD	RESS, CITY, STATE, ZIP C	ODE	
T THEF	ESE HOME			8000 BASS L NEW HOPE	LAKE ROAD E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAG	ROVIDER'S PLAN OF COP CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 325	Continued From pa	ae 3	F 3	25			
F 323	dementia, weight lo Her diet order inclu texture and thin liqu of one can of choco daily, starting 6/18/ recommendation. Review of R219's V from 3/3/14, throug resident had a grad 20.5 pounds) over the significant weight lo on 2/14/15. The foll this summary: On 3/3/14, R21 126.2 pounds. On 3/3/14, R21 126.2 pounds. On 4/14/14, he 124.4 pounds. On 6/2/14, her pounds. On 6/2/14, her pounds. On 6/2/14, her pounds. On 7/7/14, her pounds. On 8/4/14, her pounds. On 8/4/14, her pounds. On 9/1/14, her pounds. On 9/1/14, her pounds.	Ige 3 biss, and muscle weakness. ded a regular diet with regular uids. A nutritional supplement blate ensure was ordered once 14, for weight loss per dietary Veights and Vitals Summary h 3/4/15, indicated the lual weight loss of 16.2% (or the span of one year, with biss warnings/alerts beginning lowing data was included in 9's weight was recorded as r weight was recorded as 120.2 weight was recorded as 120.2 weight was recorded as 118.2 hary noted a significant weight of 11.5% (or 15.4 pounds), orded weight of 133.6 pounds supplement was initiated on e to R219's weight loss.] weight was recorded as 119.2 weight was recorded as 119.4 weight was recorded as 117.0 r weight was recorded as	F3	discontin his moth goal for The car goal of a for comb nutrition Dieticiar On 3/1 with pote identifier resident re-weigh resident monitori complet impleme updated or family Month evaluate of care loss plan prevent weight a and goa policy w definitio facility S reviewer Nurse M and at N 3/25/15. include	nued. Resident's so her's plan of care wit resident to be kept of e plan was updated accepting food and f fort. Resident was a n risk monitoring for land n evaluations. 1/15 residents on lo ential weight loss co d. Re-weights on the ts were requested on hts confirmed a weight twas added to the N ing and a Nutrition et ented as needed and d to support clinical, y goals for nutrition. If weight loss report ented as needed and d to support clinical, y goals for nutrition. If weight loss report ed by Clinical Nutriti will be reviewed to en and goals are resi further weight loss, and/or honor residen als. The Significant W vas updated to includ on for gradual weight Significant Weight Los d with Clinical Nutriti Meetings on 3/17/15 Nurse Administration . Clinical Nutrition wi intake evaluation on sessments as of 3.2	th a family comfortable. to include the fluids of choice dded to Registered ng term care oncerns were e identified n 3/12/15. If ght loss, the Jutrition Risk evaluation was ventions were d care plan resident and ts will be ion. The plan ensure weight dent driven to maintain nt preference Veight Loss de the facility loss. The poss policy was ion on 3/24/15, and 3/19/15 meeting on ill begin to a quarterly	
	116.7 pounds. • On 1/2/15, her pounds.	r weight was recorded as weight was recorded as 116.0 r weight was recorded as		docume Clinica observa	as of 3.2 ant evaluation in clini Il Nutrition will comp ations on residents ic oss every one montl	ical software. lete dentified with	

Facility ID: 00261

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		& MEDICAID SERVICES			OMB NO.	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245518	B. WING _		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ST THEF	RESE HOME			8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 325	107.6 pounds. The weight loss warning since 1/17/15, and 12/5/14. • On 2/27/15, he 107.4 pounds. The weight loss warning since 12/5/14. • On 3/4/15, her pounds. The summ loss warning/alert of 12/5/14. Review of R219's N Record (MAR) from indicated the reside 58% of her prescrib Review of R219's q dated 12/11/14, ide loss, and directed s related to her diagn assessment did not intakes. During continuous of at 12:56 p.m. in the	age 4 summary noted a significant g/alert of 6.3% (or 7.2 pounds) 7.8% (or 9.1 pounds) since r weight was recorded as summary noted a significant g/alert of 8.0% (or 9.3 pounds) weight was recorded as 105.7 hary noted a significant weight of 9.4% (or 11.0 pounds) since Medication Administration n 6/18/14, through 3/4/15, ent consumed an average of bed nutritional supplement. Juarterly Nutrition Assessment ntified no significant weight staff to anticipate her needs hosis of dementia. The t assess R219's food or fluid observation of lunch on 3/4/15, first floor dining room, R219 eated in her wheelchair at the	F 32	25 months and quarterly for one y ensure plan of care supports of nutrition plan and honoring res family goals. Summaries of the observations will be reported a Facility Clinical Quality Improve meeting. Clinical Director and Dietician are responsible for co	linical ident and/or e t the ement Registered	
	asleep in her wheel assisted with eating R219's meal was d remained asleep in interactions with sta (A)-A approached F her up and began to few bites, A-A left to to their room, and r over feeding R219 Throughout the me closed, however, sh	At 1:09 p.m., R219 remained lchair, while a tablemate was g their meal. At 1:23 p.m., elivered to her, however, she her chair, with no cues or aff. At 1:26 p.m., Activities R219 and attempted to wake o assist her with eating. After a b assist another resident back egistered nurse (RN)-A took until A-A returned at 1:37 p.m. al R219's eyes remained he did open her mouth and tost prompts to do so. R219				

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245518 B. WING 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 325 Continued From page 5 F 325 ate at a very slow pace until 1:47 p.m., when she no longer responded to A-A's prompts to open her mouth or take a bite of her food, and the resident was brought back to her room. At the completion of her meal, R219 had consumed less than 10% of her meal and approximately 50% of her fluids. During interview on 3/4/15, at 2:00 p.m. A-A stated R219 typically demonstrated poor intake during meals. During interview on 3/5/15, at 9:21 a.m. dietary manager (DM) and registered dietician (RD) stated R219's intake was usually good for the breakfast meal, but varied at lunch and supper meals. DM stated R219 had ongoing trending weight loss, but her weight tended to fluctuate and go up and down. RD stated when R219 demonstrated poor intake or refusals, the staff were expected to re-approach R219 and try again to encourage more intake. The DM stated documentation of resident intakes were not part of the medical record and were destroyed after she reviewed intakes, so there were no intake records available to review for R219 to determine if there was a pattern. The DM stated R219's weight taken on 2/15/15, of 108.6 pounds did not qualify her as significant weight loss, but she was keeping a eye on the residents weight. The DM stated it was not until R219's weight of 105.7 pounds taken on 3/4/15, that R219, "Qualified," as a significant weight loss, resulting in a referral to the RD for evaluation and recommendations. The RD stated she was not alerted to weight loss concerns for R219 until 3/4/15, after she received a referral from the physician. During interview on 3/5/15, at 1:51 p.m. the director of nursing (DON) stated each resident was weighed monthly, and gradual weight loss

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PRINTED: 03/26/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DA			E SURVEY PLETED
		245518	B. WING			03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE HOME				000 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 F 329 SS=D	should have been id quarterly nutrition a: The DON stated thi to the dietician either feeding residents, or sheets. The facility's Signific 12/10, directed nurs resident's weight de more in the past 30 responsible for revie initiating a three day needed. The DM was evaluation of prescr The DOM was to in nursing (ADON) of due to significant we address the process weight loss. 483.25(I) DRUG RE UNNECESSARY D Each resident's drug unnecessary drugs drug when used in a duplicate therapy); without adequate m indications for its us adverse consequent should be reduced of combinations of the Based on a compre- resident, the facility who have not used given these drugs u	dentified between the DM's ssessments and poor intakes. s should have been reported er by those who assisted with or via intake documentation cant Weight Loss policy dated sing staff to alert the DM if a ecreased by five pounds or days. The DM was then ewing appetite records and y or longer intake record if as also responsible for ribed dietary supplements. form the assistant director of any new recommendations eight loss. The policy did not s for identification of gradual EGIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 3				4/4/15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY PLETED
		245518	B. WING	i		03/0	05/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THER	ESE HOME				000 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	record; and residen drugs receive gradu behavioral interven	ge 7 locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F	329			
	by: Based on observat review, the facility fa monitoring for the u for 1 of 5 residents unnecessary medic Findings include: R125's physician or diagnoses including Medication orders i Solution, injecting 2 Levemir FlexPen S times daily. Both m insulin used to mair sugars. The physici monitoring for R125 test used to evaluat a period of approxir completed on 12/23 R125's Medication A from 12/1/14, throu and Levemir were r	rders signed 11/7/14, indicated g insulin dependent diabetes. ncluded NovoLOG FlexPen 20 units three times daily, and olution, injecting 48 units two nedications were types of ntain adequate control of blood ian orders directed lab 5's hemoglobin A1C (a blood te control of blood sugars over nately three months) to be			The physician was contacted on 3/s and order obtained for HGB A1C wh was obtained on 3/6/15. Results of t HGB A1C was communicated to the physician on 3/6/15. Physician visite resident on 3/6/15 and Nurse Practi- visited resident on 3/9/15 with no ch to insulin orders. Facility identified all long term care residents with the diagnosis of diaba and the use of insulin. Chart reviews completed by 3/26/15 to ensure HG A1C's were ordered and obtained or past year per physician/nurse practi- order. All residents found in complia except one resident found to have the most recent HGB A1C obtained in January 2014. The physician was contacted and an order obtained for HGB A1C on 3/26/15. F329 Unnecessary Drugs Educati- was provided to members of Nursin Administration on 3/23/15. The educ- was directed to the staff responsible physician order reviews, follow up op pharmacy medication regimen review	hich the ed tioner hanges etes s were B ver the tioner ance, he r a on g cation e for n	

Facility ID: 00261

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION (X	(3) DATE	0938-039 SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMP	PLETED
		245518	B. WING _			03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE HOME				000 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 329	hemoglobin A1C wa R125 was observed on 3/5/15, from 8:2 signs or symptoms hyperglycemia, or of effects. During interview on registered nurse (F coordinator) reporte hemoglobin A1C la R125, at the freque which indicated one on 12/23/14. RN-A hemoglobin A1C la 5/1/14, and one had 12/23/14. RN-A hemoglobin A1C la 5/1/14, and one had 12/23/14, as ordered During a telephone p.m. consultant pha resident on insulin A1C completed eve control of blood sug During interview on and health unit coo nurse practitioners monitoring their ow the responsibility of RN-B stated the fac were ordered on a and HUC-A stated fac a new system for la During interview on director of nursing	as completed on 5/1/14. d on 3/4/15, at 12:00 p.m., and 7 a.m. to 8:41 a.m., with no of hypoglycemia, other adverse medication side a 3/5/15, at 9:10 a.m. RN)-A (R125's clinical care ed it was her expectation that bs were to be completed for ency indicated by the physician, e should have been completed a stated the most recent b completed on R125 was on d not been completed on ed. interview on 3/5/15, at 1:36 armacist (CP)-A stated a should have a hemoglobin ery three months to evaluate gars overtime. a 3/5/15, at 1:14 p.m. RN-B rdinator (HUC)-A stated the were responsible for m lab orders, and it was not f the facility nursing staff. cility had very few labs which routine basis for any resident, the facility had recently begun	F 32	29	and coordination of cares through the Resident Assessment process. This f CEU education class included F329 requirements for medication administration, medication monitoring medication regimen reviews, Gradual Dose Reductions and the need for late monitoring including HgB A1C's for us insulin. F329 case scenarios for medication monitoring were also reviewed. A follow up competency wil distributed with a return date of 4/2/14 F329 education packet was distribute the facility House Supervisors on 3/25 that included content from F329, Grad Dose Reduction requirements and a resource article. A list of diabetic residents with order insulin will be obtained and HGB A1C orders/results verified on a monthly ba times three and quarterly times one y Summary of the observations will be reviewed at the facility Clinical Quality Improvement meeting. Clinical Director responsible for compliance.	1 g, l b se of ll be 4. ed to 3/15 dual ers for c vasis rear.	

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		AND HUMAN SERVICES			-	M APPROVE D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245518	B. WING	i	0	3/05/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ST THEF	ESE HOME				8000 BASS LAKE ROAD NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 329 F 428 SS=D	the physician, howe nursing. She stated responsible for han lab orders were trait to be completed tim draw. 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist mut the attending physic	tated labs were generated by ever, they were not tracked by I the facility HUC's were I dling lab orders, ensuring the Inscribed, put on the calendar nely, and setting up the lab EGIMEN REVIEW, REPORT	F :			4/4/15
	by: Based on interview facility consultant p lack of routine lab r for 1 of 5 residents, unnecessary medic Findings include: R125's physician or diagnoses including Medication orders i Solution, injecting 2 Levemir FlexPen S	NT is not met as evidenced y and document review, the harmacist failed to identify the nonitoring for the use of insulin , (R125) reviewed for cations. rders signed 11/7/14, indicated g insulin dependent diabetes. ncluded NovoLOG FlexPen 20 units three times daily, and olution, injecting 48 units two nedications were types of			The physician was contacted on 3/5/15 and order obtained for HGB A1C which was obtained on 3/6/15. Results of the HGB A1C was communicated to the physician on 3/6/15. Physician visited resident on 3/6/15 and Nurse Practitioner visited resident on 3/9/15 with no change to insulin orders. The Clinical Director dialogued with the facility Consulting Pharmacist on 3/6/15 to review clinical finding of missing HGB A1C as it relates to F329. Facility identified all long term care residents with the diagnosis of diabetes	

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	-	AND HUMAN SERVICES				FORM	03/26/201 APPROVEI <u>0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245518	B. WING _			03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE HOME						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 428	Continued From pa	ge 10	F 42	28			
	insulin used to main sugars. The physic monitoring for R128 test used to evaluat a period of approxin completed on 12/23 R125's Medication a from 12/1/14, throu and Levemir were r R125's medical rec hemoglobin A1C wa During interview on registered nurse (R coordinator) reports hemoglobin A1C lal R125, at the freque which indicated one on 12/23/14. RN-A hemoglobin A1C lal 5/1/14, and one had 12/23/14, as ordered During a telephone p.m. consultant pha resident on insulin A1C completed eve control of blood sug confirmed routine la should have been in medication regimer is reviewing the res During interview on and health unit coo nurse practitioners	htain adequate control of blood ian orders directed lab 5's hemoglobin A1C (a blood te control of blood sugars over mately three months) to be 3/14. Administration Record (MAR) gh 2/28/14, indicated NovoLog routinely administered to R125. ord indicated the most recent as completed on 5/1/14. 3/5/15, at 9:10 a.m. N)-A (R125's clinical care ed it was her expectation that bs were to be completed for ency indicated by the physician, a should have been completed a stated the most recent b completed on R125 was on d not been completed on ed. interview on 3/5/15, at 1:36 armacist (CP)-A stated a should have a hemoglobin ery three months to evaluate gars overtime. Pharmacist-A ab monitoring such as this, dentified during monthly n reviews when the pharmacist			and the use of insulin. Chart review completed by 3/26/15 to ensure H A1C's were ordered and obtained past year per physician/nurse prace order. All residents were found to compliance, except one resident w found to have the most recent HG results in January 2014. The phys was contacted and an order obtain HGB A1C on 3/26/15. Dialogue with the Consultant Pharmacist, Clinical Director and Assistant Director of Nursing for G Improvement related to F329 and Medication Regimen Reviews occ 3/24/15. The facility expectation is are completed at the frequency dif by the physician or nurse practition Consultant Pharmacist will review need for laboratory monitoring whe clinically relevant and make recommendations via the Medicat Regimen Review forms to commu to the physician. The "consultant pharmacist" referenced in the MDI survey was the facility's dispensing pharmacist. The facility consulting pharmacist agrees with the need f A1C monitoring every three month the use of insulin for the general population, but in the elderly popu the need for less frequent HGB A1 even the absence of these labs m ordered by the physician or nurse practitioner when the resident has comfort focus, end of life or Hospi F329 Unnecessary Drugs Educat was provided to members of Nurs Administration on 3/23/15. This 1	GB over the stitioner be in vas B A1C ician hed for a uality urred on labs ected her. the en nicate H or HGB is for ation, C's or ay be a ce. stion ing	

Facility ID: 00261

If continuation sheet Page 11 of 12

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DAT	<u>0936-039</u> E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COM	PLETED
		245518	B. WING _		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST THEF	RESE HOME			8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 428	the responsibility of RN-B stated the fac were ordered on a and HUC-A stated a new system for la During interview on director of nursing expectation labs we frequency directed practitioner. She st medication monitor of labs, were to be	f the facility nursing staff. cility had very few labs which routine basis for any resident, the facility had recently begun	F 42	class included F329 requirement medication administration, media regimen reviews and monitoring. Dose Reductions and the need f monitoring including HGB A1C's insulin. The FTag case scenarios medication monitoring were also reviewed. A follow up competent distributed with a return date of 4 F329 education packet was distr the facility House Supervisors or that included content from F329, Dose Reduction requirements ar resource article. A list of diabetic residents with insulin will be obtained and HGB verified on a monthly basis times and quarterly times one year. In a comparison review will be com checking that the facility consulta pharmacists Medication Regime Reviews have addressed orders A1Cs in the use of insulin. Sum the observations will be reviewed facility Clinical Quality Improvem meeting. Clinical Director and Co Pharmacist are responsible for compliance.	eation Gradual for lab for use of for ey will be /2/14. A ibuted to 3/23/15 Gradual nd a orders for A1C's three addition, pleted int n for HGB mary of I at the ent	

Facility ID: 00261

If continuation sheet Page 12 of 12

	MENT OF HEALTH		ices F	55180		FORM	03/06/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245518		B. WING		03/04	4/2015
	ROVIDER OR SUPPLIER			RESS, CITY, S ASS LAKE	TATE, ZIP CODE		
ST THEF				OPE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	Minnesota Departm time of this survey, in substantial comp for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapt St. Therese Home i basement. The build different times. The constructed in 1968 Type I (332) constru- was constructed to determined to be of 1999, an addition w westside of the 1st be of Type I (332). constructed in 2003 was determined to the 3rd floor was det the building was do Being that the cons exiting building, the building. The buildif facility has a fire ala detection in the corr corridors that are m department notifica The facility has a ca census of 245 at the	Standard 101, Life ar 19 Existing Health is a 3-story building was original building was and was determine action. In 1973, an a the 3rd floor that was Type II (111) constru- ras constructed to the floor that was determ Another addition was to the 2nd and 3rd be of Type I (332). E etermined to be Type wngraded to Type II truction type is allow building is surveyed ing is fully fire sprinklarm system with smo- ridors and spaces op ionitored for automa	At the vas found rements t 42 CFR, e, and the Safety n Care. with no ed at 4 is d to be of addition s uction. In e nined to s floor that Because e II (111), (111). ed for an as one led. The oke ben to the tic fire				
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted March 16, 2015

Ms. Dinah Martin, Administrator St Therese Home 8000 Bass Lake Road New Hope, Minnesota 55428

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5518025

Dear Ms. Martin:

The above facility was surveyed on March 2, 2015 through March 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00261	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THEP	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	You may request a that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/26/15

STATE FORM

If continuation sheet 1 of 16

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00261	B. WING		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ST THEF	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On March 2nd, 3rc of this Department" provider and the fol issued. Please ind	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health. d, 4th and 5th 2015 surveyors is staff, visited the above llowing correction orders are icate in your electronic plan of have reviewed these orders,				
	and identify the dat Minnesota Departm the State Licensing federal software. Ta	e when they will be completed. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		00261	B. WING		03/	/05/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
ST THER	ESE HOME		SS LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 435	MN Rule 4658.0210 Assignments	) Subp. 2 A.B. Room	2 435			3/27/15
	must develop and in procedures for add including complaint and roommates. A procedures must in A. a mechanism resolution of room complaints; and	complaints. A nursing home mplement written policies and ressing resident complaints, s regarding room assignments t a minimum, the policies and clude the following: n for informal dispute assignment and roommate for documenting the complain	5			
	by: Based on observati review, the facility fa (R183) reviewed for	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 1 resident r admission, transfer, and notification prior to receiving		Corrected.		
	Findings include:					
		Ainimum Data Set (MDS) icated the resident had no nt.				
	member (FM)-A sta	3/4/15, at 9:33 a.m. family ted R183 had several new er admission in December,				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00261	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ST THEF	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	ION SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DATE
2 435	Continued From pa	ige 3	2 435			
	and had not been in into the room.	nformed prior to them moving				
	room from her adm Transitional care ur	ssion Report regarding R183's iission on 12/18/14, to the nit (TCU) through 3/15, I four different roommates.				
	reviewed from her a the survey and con	Nursing Progress Notes were admission through the dates or tained no information s informed of any of the 4 i into her room.	f			
	was in her room ea and oriented. During interview on stated R183 had se since admission an of them beforehand During interview on stated she had a "L	3/05/15, at 9:23 a.m. R183 .ot" of new roommates since				
	"Just wheel them ir notify her when a n into her room. R18 her and stated it wo warning."	o the facility, and staff would " to the room and did not ew resident was being moved 3 stated this was disruptive to build be, "Nice to have more				
	worker (SW)-A stat TCU were made av Admission Informat frequent roommate	3/05/15, at 11:05 a.m. social ed residents admitted to the ware on the Social Service tion form there may be changes, so the residents did e notice of a roommate				
	change. R183's undated So Information form in demand for placem	cial Service Admission dicated due to the high tent on the TCU, residents roommate the same day the				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	X3) DATE S COMPL	
		00261	B. WING		03/05	5/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 435	previous roommate The facility policy tit indicated the social currently in the roor new roommate. SUGGESTED MET The Director of Nur resident charts on t advance notice of ro Quality Assurance ( review the audits to	-	2 435			
2 965	-Nutritional Status Subpart. 2. Nutritio must ensure that a which supplies the determined by the c assessment. Subs	O Subp. 2 Dietary Service nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			3/26/15
	by: Based on observati review, the facility fa implement interven residents, (R219) re Findings include: R219's quarterly Mi	ent is not met as evidenced on, interview, and document ailed to identify, assess, and tions for weight loss for 1 of 3 eviewed for weight loss. nimum Data Set (MDS) dated the resident had server		Corrected		

Minnesota Department of Health STATE FORM

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JJFL11

If continuation sheet 5 of 16

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00261	B. WING		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ST THEI	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 5	2 965			
	assistance with eat loss, and was not o planned weight loss R219's current physi identified diagnoses dementia, weight lo Her diet order inclu texture and thin liqu of one can of choco daily, starting 6/18/ recommendation. Review of R219's V from 3/3/14, throug resident had a grac 20.5 pounds) over f significant weight lo on 2/14/15. The foll this summary: On 3/3/14, R21 126.2 pounds. On 5/5/14, her pounds. On 5/5/14, her pounds. On 6/2/14, her pounds. On 7/7/14, her pounds. On 8/4/14, her pounds. On 9/1/14, her pounds.	nt, required extensive ing, had no significant weight on a physician prescribed/ s program. sician orders signed 2/5/15, s including psychosis, oss, and muscle weakness. ded a regular diet with regular uids. A nutritional supplement olate ensure was ordered once 14, for weight loss per dietary Weights and Vitals Summary h 3/4/15, indicated the dual weight loss of 16.2% (or the span of one year, with oss warnings/alerts beginning lowing data was included in 9's weight was recorded as r weight was recorded as 120.2 weight was recorded as 118.2 hary noted a significant weight of 11.5% (or 15.4 pounds), orded weight of 133.6 pounds supplement was initiated on ie to R219's weight loss.] weight was recorded as 119.2 weight was recorded as 119.4 weight was recorded as 117.0 r weight was recorded as				

STATE FORM

JJFL11

If continuation sheet 6 of 16

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
0		00261	B. WING	B. WING		05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ST THEF	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 6	2 965			
	· On 12/5/14. he	r weight was recorded as				
	116.7 pounds.	<u>.</u>				
		weight was recorded as 116.0				
	pounds.	J				
		• On 2/14/15, her weight was recorded as				
	107.6 pounds. The summary noted a significant					
	weight loss warning/alert of 6.3% (or 7.2 pounds)					
		since 1/17/15, and 7.8% (or 9.1 pounds) since				
	12/5/14.					
		r weight was recorded as				
		summary noted a significant				
	weight loss warning/alert of 8.0% (or 9.3 pounds)					
	since 12/5/14.					
	• On 3/4/15, her weight was recorded as 105.7					
	pounds. The summary noted a significant weight					
	loss warning/alert c	loss warning/alert of 9.4% (or 11.0 pounds) since				
		Medication Administration				
		n 6/18/14, through 3/4/15,				
		ent consumed an average of				
		ped nutritional supplement.				
		Review of R219's quarterly Nutrition Assessment				
		ntified no significant weight				
	loss, and directed s	staff to anticipate her needs				
	related to her diagn	nosis of dementia. The				
		t assess R219's food or fluid				
	intakes.					
		observation of lunch on 3/4/15	,			
		first floor dining room, R219				
		eated in her wheelchair at the				
		At 1:09 p.m., R219 remained				
		Ichair, while a tablemate was				
		g their meal. At 1:23 p.m.,				
		elivered to her, however, she				
		her chair, with no cues or				
		aff. At 1:26 p.m., Activities R219 and attempted to wake				
		o assist her with eating. After a o assist another resident back				
		registered nurse (RN)-A took				
	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00261		00001	B. WING			
		00261	D. WING		03/	05/2015
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
T THEF	ESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 965	Continued From pa	ge 7	2 965			
	over feeding R219	until A-A returned at 1:37 p.m.				
		al R219's eyes remained				
	closed, however, sh	ne did open her mouth and				
		ost prompts to do so. R219				
		ace until 1:47 p.m., when she				
	no longer responded to A-A's prompts to open her mouth or take a bite of her food, and the					
		<i>,</i>				
		nt back to her room. At the neal, R219 had consumed less				
		al and approximately 50% of	<b>,</b>			
	her fluids.					
	During interview on 3/4/15, at 2:00 p.m. A-A					
	stated R219 typically demonstrated poor intake					
	during meals.					
		3/5/15, at 9:21 a.m. dietary				
		registered dietician (RD)				
		e was usually good for the				
		varied at lunch and supper				
		219 had ongoing trending weight tended to fluctuate				
		n. RD stated when R219				
		intake or refusals, the staff				
		-approach R219 and try agair	1			
		intake. The DM stated				
		esident intakes were not part				
	of the medical reco	rd and were destroyed after				
		es, so there were no intake				
		review for R219 to determine				
		rn. The DM stated R219's				
		5/15, of 108.6 pounds did not				
		icant weight loss, but she was				
		e residents weight. The DM til R219's weight of 105.7				
		4/15, that R219, "Qualified,"				
		ght loss, resulting in a referral				
		ation and recommendations.				
		was not alerted to weight loss				
		until 3/4/15, after she received				
	a referral from the p					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00261	B. WING		03/05/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T THER	ESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
RÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	ge 8	2 965			
	director of nursing ( was weighed month should have been in quarterly nutrition a The DON stated this to the dietician either	3/5/15, at 1:51 p.m. the DON) stated each resident hly, and gradual weight loss dentified between the DM's ssessments and poor intakes s should have been reported er by those who assisted with or via intake documentation				
	12/10, directed nurs resident's weight de more in the past 30 responsible for revi initiating a three day needed. The DM we evaluation of presc The DOM was to in nursing (ADON) of due to significant w	cant Weight Loss policy dated sing staff to alert the DM if a ecreased by five pounds or days. The DM was then ewing appetite records and y or longer intake record if as also responsible for ribed dietary supplements. form the assistant director of any new recommendations eight loss. The policy did not s for identification of gradual				
	The dietician or des charts for unintende could review and re procedures related staff regarding the Assurance Commit	HOD OF CORRECTION: signee could audit resident ed weight loss. The dietician vise facility policies and to weight loss and educate all changes. The Quality tee could review audit re ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	) A.B.C Drug Regimen Reviev	v 21530			4/4/15

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
	00261		B. WING		03/05/2015		
NAME OF	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
פד דוובו	RESE HOME	8000 BA	SS LAKE ROA	ND			
		NEW HO	PE, MN 55428	8			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From pa	ge 9	21530				
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the o and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the act report and the signi of nursing services C. If the attendit with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician does not must be referred for assessment and as by part 4658.0070. the medical directo must refer the matter	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the rrposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.					

Minnesc	ota Department of He	ealth			FUNIV	APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
ANDTLAN	OF CONTLETION	IDENTIFICATION NOMBER.	A. BUILDING		CON	
		00261	B. WING		03/05/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
ST THEE	RESE HOME		SS LAKE RC			
0		NEW HO	PE, MN 554	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 10	21530			
	by: Based on interview facility consultant p lack of routine lab r	ent is not met as evidenced r and document review, the harmacist failed to identify the monitoring for the use of insulir , (R125) reviewed for cations.		Corrected		
	Findings include:					
	diagnoses including Medication orders i Solution, injecting 2 Levemir FlexPen S times daily. Both n insulin used to mai sugars. The physic monitoring for R12 test used to evalua	rders signed 11/7/14, indicated g insulin dependent diabetes. included NovoLOG FlexPen 20 units three times daily, and colution, injecting 48 units two nedications were types of ntain adequate control of blood ian orders directed lab 5's hemoglobin A1C (a blood te control of blood sugars over mately three months) to be 3/14.	4			
	from 12/1/14, throu	Administration Record (MAR) 19h 2/28/14, indicated NovoLog 19troutinely administered to R125				
		cord indicated the most recent as completed on 5/1/14.				
	registered nurse (F coordinator) reports hemoglobin A1C la R125, at the freque which indicated one on 12/23/14. RN-A hemoglobin A1C la	a 3/5/15, at 9:10 a.m. RN)-A (R125's clinical care ed it was her expectation that bs were to be completed for ency indicated by the physician e should have been completed a stated the most recent b completed on R125 was on d not been completed on				

a Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		
		A. BUILDING: _			E SURVEY PLETED
	00261	B. WING		03/05/2015	
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ESE HOME					
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Continued From pa	ge 11	21530			
12/23/14, as ordere	ed.				
p.m. consultant pha resident on insuling A1C completed ever control of blood sug confirmed routine la should have been in medication regimer is reviewing the res During interview on and health unit cool nurse practitioners monitoring their ow the responsibility of RN-B stated the fac were ordered on a n and HUC-A stated the	armacist (CP)-A stated a should have a hemoglobin ery three months to evaluate gars overtime. Pharmacist-A ab monitoring such as this, dentified during monthly n reviews when the pharmacist ident medications. 3/5/15, at 1:14 p.m. RN-B rdinator (HUC)-A stated the were responsible for n lab orders, and it was not the facility nursing staff. cility had very few labs which routine basis for any resident, the facility had recently begun				
During interview on director of nursing ( expectation labs wo frequency directed practitioner. She sta medication monitor of labs, were to be pharmacist during r reviews. SUGGESTED MET The administrator, of consulting pharmac policies and proced medication usage. I educated as neces	3/5/15, at 1:51 p.m. the DON) stated it was her build be completed at the by the physician or nurse ated appropriate/ necessary ing, including the completion evaluated by the consultant nonthly medication regimen THOD OF CORRECTION: director of nursing (DON) and cist could review and revise ures for proper monitoring of Nursing staff could be sary to the importance of the				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From pa 12/23/14, as ordered During a telephone o.m. consultant pha resident on insulin s A1C completed even control of blood sug confirmed routine la should have been in medication regimer s reviewing the res During interview on and health unit cool nurse practitioners monitoring their ow he responsibility of RN-B stated the fact were ordered on a ta and HUC-A stated ta a new system for la During interview on director of nursing ( expectation labs wo requency directed oractitioner. She sta nedication monitor of labs, were to be obarmacist during r eviews.	SE HOME         NEW HOI           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 11           12/23/14, as ordered.           During a telephone interview on 3/5/15, at 1:36 0.m. consultant pharmacist (CP)-A stated a resident on insulin should have a hemoglobin A1C completed every three months to evaluate control of blood sugars overtime. Pharmacist-A confirmed routine lab monitoring such as this, should have been identified during monthly medication regimen reviews when the pharmacist s reviewing the resident medications.           During interview on 3/5/15, at 1:14 p.m. RN-B and health unit coordinator (HUC)-A stated the nurse practitioners were responsible for monitoring their own lab orders, and it was not he responsibility of the facility nursing staff. RN-B stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had recently begun a new system for labs.           During interview on 3/5/15, at 1:51 p.m. the director of nursing (DON) stated it was her expectation labs would be completed at the requency directed by the physician or nurse practitioner. She stated appropriate/ necessary medication monitoring, including the consultant oharmacist during monthly medication regimen eviews.           SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the oharmacist's review. The DON or designee, along with the pharmacist, could audit medication	SE HOME         NEW HOPE, MN 55428           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 11         21530           12/23/14, as ordered.         21530           During a telephone interview on 3/5/15, at 1:36 0.m. consultant pharmacist (CP)-A stated a resident on insulin should have a hemoglobin A1C completed every three months to evaluate control of blood sugars overtime. Pharmacist-A confirmed routine lab monitoring such as this, should have been identified during monthly medication regimen reviews when the pharmacist s reviewing the resident medications.           During interview on 3/5/15, at 1:14 p.m. RN-B and health unit coordinator (HUC)-A stated the nurse practitioners were responsible for monitoring their own lab orders, and it was not he responsibility of the facility nursing staff.           RN-B stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had recently begun a new system for labs.           During interview on 3/5/15, at 1:51 p.m. the director of nursing (DON) stated it was her expectation labs would be completed at the requency directed by the physician or nurse practitioner. She stated appropriate/ necessary medication monitoring, including the consultant pharmacist during monthly medication regimen eviews.           SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be aducated as necessary to the importance of the pharmacist's review. The DON or designee, along with the	New HOPE, MN 5328           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PREFIX CACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION)           Continued From page 11         21530         21530           12/23/14, as ordered.         21530           During a telephone interview on 3/5/15, at 1:36 o.m. consultant pharmacist (CP)-A stated a esident on insulin should have a hemoglobin ATC completed every three months to evaluate control of blood sugars overtime. Pharmacist-A control of blood sugars overtime. Pharmacist-A sonfirmed routine lab monitoring such as this, should have been identified during monthly nedication regimen reviews when the pharmacist s reviewing the resident medications.           During interview on 3/5/15, at 1:14 p.m. RN-B and health unit coordinator (HUC)-A stated the nurse practitioners were responsible for monitoring their own lab orders, and it was not he responsibility of the facility nursing staff.           RN-B stated the facility had very few labs which were ordered on a routine basis for any resident, an ew system for labs.           During interview on 3/5/15, at 1:51 p.m. the director of nursing (DON) stated it was her expectation labs would be completed at the requency directed by the physician or nurse oracitioner. She stated appropriate/ necessary medication monitoring, including the consultant oharmacist during monthly medication regimen eviews.           SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of nedication usage. Nursing staff could be aducated as necessary to the importance o	SE HOME         NEW HOPE, MN 55428           Isummary statement of DEFICIENCIES (EACH DEFICIENCY Must BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         ID PRETX TAG         PROVIDER'S PLAN OF CORRECTION (EACH OCHRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY MUST CROSS REFERENCET OT THE APPROPRIATE DEFICIENCY           Continued From page 11         21530         21530           12/23/14, as ordered.         21530         DEFICIENCY CROSS REFERENCES TO THE APPROPRIATE DEFICIENCY           During a telephone interview on 3/5/15, at 1:36 p.m. consultant pharmacist (CP)-A stated a esident on insulin should have a hemoglobin AIC completed every three months to evaluate control of blood sugars overtime. Pharmacist-A sonfirmed routine lab monitoring such as this, should have been identified during monthly nedication regimen reviews when the pharmacist s reviewing the resident medications.           During interview on 3/5/15, at 1:14 p.m. RN-B and health unit coordinator (HUC)-A stated the neresponsibility of the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had very few labs which were ordered on anothy medication regimen eviews.         SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be aducated as necessary to the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 03/05/2015	
	00261		B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	•	
ST THEF	RESE HOME		SS LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21530	Continued From pa	ge 12	21530			
	reviews on a regula	r basis to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			4/4/15
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medic medical director is not the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee re the attending physic	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the hal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	J			
	by: Based on observati review, the facility fa monitoring for the u	ent is not met as evidenced on, interview, and document ailed to ensure routine lab ise of insulin was completed (R125) reviewed for tations.		Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00261	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ST THEF	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From pa	ige 13	21540			
	Findings include:					
	diagnoses including Medication orders i Solution, injecting 2 Levemir FlexPen S times daily. Both m insulin used to main sugars. The physic monitoring for R128 test used to evalua	rders signed 11/7/14, indicated g insulin dependent diabetes. ncluded NovoLOG FlexPen 20 units three times daily, and olution, injecting 48 units two nedications were types of ntain adequate control of blood ian orders directed lab 5's hemoglobin A1C (a blood te control of blood sugars over mately three months) to be 3/14.	1			
	from 12/1/14, throu	Administration Record (MAR) gh 2/28/14, indicated NovoLog routinely administered to R125				
		ord indicated the most recent as completed on 5/1/14.				
	on 3/5/15, from 8:2 signs or symptoms	d on 3/4/15, at 12:00 p.m., and 7 a.m. to 8:41 a.m., with no of hypoglycemia, ther adverse medication side				
	registered nurse (R coordinator) reports hemoglobin A1C la R125, at the freque which indicated one on 12/23/14. RN-A hemoglobin A1C la	a 3/5/15, at 9:10 a.m. N)-A (R125's clinical care ed it was her expectation that bs were to be completed for ency indicated by the physician e should have been completed a stated the most recent b completed on R125 was on d not been completed on ed.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
002		00261	B. WING		03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE. ZIP CODE		
			SS LAKE ROA			
SITHEF	RESE HOME	NEW HOI	PE, MN 55428	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From pa	ige 14	21540			
	Continued From page 14 During a telephone interview on 3/5/15, at 1:36 p.m. consultant pharmacist (CP)-A stated a resident on insulin should have a hemoglobin A1C completed every three months to evaluate control of blood sugars overtime. During interview on 3/5/15, at 1:14 p.m. RN-B and health unit coordinator (HUC)-A stated the nurse practitioners were responsible for monitoring their own lab orders, and it was not the responsibility of the facility nursing staff. RN-B stated the facility had very few labs which were ordered on a routine basis for any resident, and HUC-A stated the facility had recently begun a new system for labs. During interview on 3/5/15, at 1:51 p.m. the director of nursing (DON) stated it was her expectation labs would be completed at the frequency directed by the physician or nurse practitioner. DON stated labs were generated by					
	nursing. She stated responsible for han lab orders were tran to be completed tim draw. SUGGESTED MET The Director of Nur work with the medic pharmacist to ensu for appropriate inter DON could ensure importance of moni medications.The Do	ever, they were not tracked by I the facility HUC's were dling lab orders, ensuring the nscribed, put on the calendar nely, and setting up the lab THOD OF CORRECTION: rsing (DON) or desigee could cal director and consultant re medications were reviewed rventions and monitoring. The the staff were educated on the itoring for unnecessary ON or designee could				
		dent records to ensure g and documentation was in				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00261	B. WING		03/05/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
T THER	ESE HOME		SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ge 15	21540			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				