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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JJFL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00261

1. 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** (L6) **55428**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/23/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **258** (L18)

13.Total Certified Beds **258** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	258			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 04/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/07/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245518	A. Building B. Wing	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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **03/27/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/26/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/04/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/04/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	4/30/2015	32208	4/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/5/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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	(Y2) Multiple Construction	(Y3) Date of Revisit
00261	A. Building B. Wing	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 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** Reg. # **MN Rule 4658.0210 Subp. 2 A.I** LSC	Correction Completed **03/27/2015**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp. 2** LSC	Correction Completed **03/26/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **04/04/2015**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **04/04/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	04/30/2015	32208	4/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/5/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JJFL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00261

1. 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** (L6) **55428**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/05/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **258** (L18)

13.Total Certified Beds **258** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	258			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	03/05/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R183) reviewed for admission, transfer, and discharge received notification prior to receiving new roommates. Findings include: R183's admission Minimum Data Set (MDS) dated 12/24/14, indicated the resident had no cognitive impairment. During interview on 3/4/15, at 9:33 a.m. family member (FM)-A stated R183 had several new	F 247	Resident admitted on 12/18/14 and signed the admission paperwork that included the social service admission information which explained that she was admitted to a shared room and due to the high demand for placement on the TCU she might receive a new roommate the same day that her previous roommate moved out or discharged. On 3/9/15, the resident was going to be receiving a new roommate and she was informed of this. All TCU residents living in shared rooms that would have received a new room-mate could have been affected by	3/27/15

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

Electronically Signed | 03/26/2015

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	245518	A. BUILDING _____ B. WING _____	03/05/2015

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

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F 247	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 receive advance notice of a roommate change. R183's undated Social Service Admission Information form indicated due to the high	F 247	this practice. On 3/10/15, Director of Social Services revised the practice and policy to include notification to TCU residents receiving a new roommate and the process of documentation. The Room Change and Notification of New Roommate policy has been updated to reflect the practice of verbally notifying a TCU resident before he or she gets a new roommate and documenting in the residents chart. Education on the policy was completed with social service on 3/10/15. On 3/27/15 a random sample of admissions to TCU will have a chart review completed to ensure the changes in the policy are being followed. An observation will be completed one time per month for the first three months and then quarterly for the following year to ensure that residents in shared rooms on the TCU are verbally notified of receiving a new roommate and notification documented in medical record. Findings from the observations will be presented at the facility clinical Quality Improvement meeting. Director of Social Services will be responsible for coordination.	

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F 247	Continued From page 2 demand for placement on the TCU, residents may receive a new roommate the same day the previous roommate discharges. The facility policy titled Room Change dated 1/13, indicated the social worker will notify the resident currently in the room that they are receiving a new roommate.	F 247		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, assess, and implement interventions for weight loss for 1 of 3 residents, (R219) reviewed for weight loss. Findings include: R219's quarterly Minimum Data Set (MDS) dated 12/11/14, identified the resident had server cognitive impairment, required extensive assistance with eating, had no significant weight loss, and was not on a physician prescribed/ planned weight loss program. R219's current physician orders signed 2/5/15, identified diagnoses including psychosis,	F 325	The Physician/Nurse Practitioner was notified of the weight loss on 3/4/15 and a Significant Change in Status Assessment, (SCSA) was opened. On 3/5/15, an additional can of Ensure was added to breakfast as well as an HS snack of ice cream and a cookie. Nutrition assessments were completed on 3/6/15 and 3/9/15. A speech therapy evaluation was obtained on 3/6/15. Resident diet was changed on 3/9/15 to Mechanical Soft with thin liquids. On 3/19/15, resident had a hospice intake and speech therapy was	3/26/15

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F 325	Continued From page 3 dementia, weight loss, and muscle weakness. Her diet order included a regular diet with regular texture and thin liquids. A nutritional supplement of one can of chocolate ensure was ordered once daily, starting 6/18/14, for weight loss per dietary recommendation. Review of R219's Weights and Vitals Summary from 3/3/14, through 3/4/15, indicated the resident had a gradual weight loss of 16.2% (or 20.5 pounds) over the span of one year, with significant weight loss warnings/alerts beginning on 2/14/15. The following data was included in this summary: · On 3/3/14, R219's weight was recorded as 126.2 pounds. · On 4/14/14, her weight was recorded as 124.4 pounds. · On 5/5/14, her weight was recorded as 120.2 pounds. · On 6/2/14, her weight was recorded as 118.2 pounds. The summary noted a significant weight loss warning/alert of 11.5% (or 15.4 pounds), compared to a recorded weight of 133.6 pounds on 12/6/13. [A daily nutritional supplement was initiated on 6/18/14, in response to R219's weight loss.] · On 7/7/14, her weight was recorded as 119.2 pounds. · On 8/4/14, her weight was recorded as 119.4 pounds. · On 9/1/14, her weight was recorded as 117.0 pounds. · On 10/6/14, her weight was recorded as 117.0 pounds. · On 12/5/14, her weight was recorded as 116.7 pounds. · On 1/2/15, her weight was recorded as 116.0 pounds. · On 2/14/15, her weight was recorded as	F 325	discontinued. Resident's son is involved in his mother's plan of care with a family goal for resident to be kept comfortable. The care plan was updated to include the goal of accepting food and fluids of choice for comfort. Resident was added to nutrition risk monitoring for Registered Dietician evaluations. On 3/11/15 residents on long term care with potential weight loss concerns were identified. Re-weights on the identified residents were requested on 3/12/15. If re-weights confirmed a weight loss, the resident was added to the Nutrition Risk monitoring and a Nutrition evaluation was completed by 3/25/15. Interventions were implemented as needed and care plan updated to support clinical, resident and or family goals for nutrition. Monthly weight loss reports will be evaluated by Clinical Nutrition. The plan of care will be reviewed to ensure weight loss plan and goals are resident driven to prevent further weight loss, maintain weight and/or honor resident preference and goals. The Significant Weight Loss policy was updated to include the facility definition for gradual weight loss. The facility Significant Weight Loss policy was reviewed with Clinical Nutrition on 3/24/15, Nurse Meetings on 3/17/15 and 3/19/15 and at Nurse Administration meeting on 3/25/15. Clinical Nutrition will begin to include intake evaluation on quarterly MDS assessments as of 3.25.15 and document evaluation in clinical software. Clinical Nutrition will complete observations on residents identified with weight loss every one month times three	

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F 325	Continued From page 4 107.6 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. · On 2/27/15, her weight was recorded as 107.4 pounds. The 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 of 9.4% (or 11.0 pounds) since 12/5/14. Review of R219's Medication Administration Record (MAR) from 6/18/14, through 3/4/15, indicated the resident consumed an average of 58% of her prescribed nutritional supplement. Review of R219's quarterly Nutrition Assessment dated 12/11/14, identified no significant weight loss, and directed staff to anticipate her needs related to her diagnosis of dementia. The assessment did not assess R219's food or fluid intakes. During continuous observation of lunch on 3/4/15, at 12:56 p.m. in the first floor dining room, R219 was asleep while seated in her wheelchair at the dining room table. At 1:09 p.m., R219 remained asleep in her wheelchair, while a tablemate was assisted with eating their meal. At 1:23 p.m., R219's meal was delivered to her, however, she remained asleep in her chair, with no cues or interactions with staff. At 1:26 p.m., Activities (A)-A approached R219 and attempted to wake her up and began to assist her with eating. After a few bites, A-A left to assist another resident back to their room, and registered nurse (RN)-A took over feeding R219 until A-A returned at 1:37 p.m. Throughout the meal R219's eyes remained closed, however, she did open her mouth and accept food after most prompts to do so. R219	F 325	months and quarterly for one year to ensure plan of care supports clinical nutrition plan and honoring resident and/or family goals. Summaries of the observations will be reported at the Facility Clinical Quality Improvement meeting. Clinical Director and Registered Dietician are responsible for compliance.	

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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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F 325	Continued From page 6 should have been identified between the DM's quarterly nutrition assessments and poor intakes. The DON stated this should have been reported to the dietician either by those who assisted with feeding residents, or via intake documentation sheets. The facility's Significant Weight Loss policy dated 12/10, directed nursing staff to alert the DM if a resident's weight decreased by five pounds or more in the past 30 days. The DM was then responsible for reviewing appetite records and initiating a three day or longer intake record if needed. The DM was also responsible for evaluation of prescribed dietary supplements. The DOM was to inform the assistant director of nursing (ADON) of any new recommendations due to significant weight loss. The policy did not address the process for identification of gradual weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		4/4/15

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F 329	Continued From page 7 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine lab monitoring for the use of insulin was completed for 1 of 5 residents (R125) reviewed for unnecessary medications. Findings include: R125's physician orders signed 11/7/14, indicated diagnoses including insulin dependent diabetes. Medication orders included NovoLOG FlexPen Solution, injecting 20 units three times daily, and Levemir FlexPen Solution, injecting 48 units two times daily. Both medications were types of insulin used to maintain adequate control of blood sugars. The physician orders directed lab monitoring for R125's hemoglobin A1C (a blood test used to evaluate control of blood sugars over a period of approximately three months) to be completed on 12/23/14. R125's Medication Administration Record (MAR) from 12/1/14, through 2/28/14, indicated NovoLog and Levemir were routinely administered to R125. R125's medical record indicated the most recent	F 329	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 changes to insulin orders. Facility identified all long term care residents with the diagnosis of diabetes and the use of insulin. Chart reviews were completed by 3/26/15 to ensure HGB A1C's were ordered and obtained over the past year per physician/nurse practitioner order. All residents found in compliance, except one resident found to have the most recent HGB A1C obtained in January 2014. The physician was contacted and an order obtained for a HGB A1C on 3/26/15. F329 Unnecessary Drugs Education was provided to members of Nursing Administration on 3/23/15. The education was directed to the staff responsible for physician order reviews, follow up on pharmacy medication regimen reviews	

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F 329	Continued From page 8 hemoglobin A1C was completed on 5/1/14. R125 was observed on 3/4/15, at 12:00 p.m., and on 3/5/15, from 8:27 a.m. to 8:41 a.m., with no signs or symptoms of hypoglycemia, hyperglycemia, or other adverse medication side effects. During interview on 3/5/15, at 9:10 a.m. registered nurse (RN)-A (R125's clinical care coordinator) reported it was her expectation that hemoglobin A1C labs were to be completed for R125, at the frequency indicated by the physician, which indicated one should have been completed on 12/23/14. RN-A stated the most recent hemoglobin A1C lab completed on R125 was on 5/1/14, and one had not been completed on 12/23/14, as ordered. 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	F 329	and coordination of cares through the Resident Assessment process. This 1 CEU education class included F329 requirements for medication administration, medication monitoring, medication regimen reviews, Gradual Dose Reductions and the need for lab monitoring including HgB A1C's for use of insulin. F329 case scenarios for medication monitoring were also reviewed. A follow up competency will be distributed with a return date of 4/2/14. F329 education packet was distributed to the facility House Supervisors on 3/23/15 that included content from F329, Gradual Dose Reduction requirements and a resource article. A list of diabetic residents with orders for insulin will be obtained and HGB A1C orders/results verified on a monthly basis times three and quarterly times one year. Summary of the observations will be reviewed at the facility Clinical Quality Improvement meeting. Clinical Director is responsible for compliance.	

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F 329	Continued From page 9 practitioner. DON stated labs were generated by the physician, however, they were not tracked by nursing. She stated the facility HUC's were responsible for handling lab orders, ensuring the lab orders were transcribed, put on the calendar to be completed timely, and setting up the lab draw.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consultant pharmacist failed to identify the lack of routine lab monitoring for the use of insulin for 1 of 5 residents, (R125) reviewed for unnecessary medications. Findings include: R125's physician orders signed 11/7/14, indicated diagnoses including insulin dependent diabetes. Medication orders included NovoLOG FlexPen Solution, injecting 20 units three times daily, and Levemir FlexPen Solution, injecting 48 units two times daily. Both medications were types of	F 428	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 changes 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	4/4/15

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F 428	Continued From page 10 insulin used to maintain adequate control of blood sugars. The physician orders directed lab monitoring for R125's hemoglobin A1C (a blood test used to evaluate control of blood sugars over a period of approximately three months) to be completed on 12/23/14. R125's Medication Administration Record (MAR) from 12/1/14, through 2/28/14, indicated NovoLog and Levemir were routinely administered to R125. R125's medical record indicated the most recent hemoglobin A1C was completed on 5/1/14. During interview on 3/5/15, at 9:10 a.m. registered nurse (RN)-A (R125's clinical care coordinator) reported it was her expectation that hemoglobin A1C labs were to be completed for R125, at the frequency indicated by the physician, which indicated one should have been completed on 12/23/14. RN-A stated the most recent hemoglobin A1C lab completed on R125 was on 5/1/14, and one had not been completed on 12/23/14, as ordered. 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. Pharmacist-A confirmed routine lab monitoring such as this, should have been identified during monthly medication regimen reviews when the pharmacist is 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	F 428	and the use of insulin. Chart reviews were completed by 3/26/15 to ensure HGB A1C's were ordered and obtained over the past year per physician/nurse practitioner order. All residents were found to be in compliance, except one resident was found to have the most recent HGB A1C results in January 2014. The physician was contacted and an order obtained for a HGB A1C on 3/26/15. Dialogue with the Consultant Pharmacist, Clinical Director and Assistant Director of Nursing for Quality Improvement related to F329 and Medication Regimen Reviews occurred on 3/24/15. The facility expectation is labs are completed at the frequency directed by the physician or nurse practitioner. Consultant Pharmacist will review the need for laboratory monitoring when clinically relevant and make recommendations via the Medication Regimen Review forms to communicate to the physician. The "consultant pharmacist" referenced in the MDH survey was the facility's dispensing pharmacist. The facility consulting pharmacist agrees with the need for HGB A1C monitoring every three months for the use of insulin for the general population, but in the elderly population, the need for less frequent HGB A1C's or even the absence of these labs may be ordered by the physician or nurse practitioner when the resident has a comfort focus, end of life or Hospice. F329 Unnecessary Drugs Education was provided to members of Nursing Administration on 3/23/15. This 1 CEU	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 11 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. She stated appropriate/ necessary medication monitoring, including the completion of labs, were to be evaluated by the consultant pharmacist during monthly medication regimen reviews.	F 428	class included F329 requirements for medication administration, medication regimen reviews and monitoring, Gradual Dose Reductions and the need for lab monitoring including HGB A1C's for use of insulin. The FTag case scenarios for medication monitoring were also reviewed. A follow up competency will be distributed with a return date of 4/2/14. A F329 education packet was distributed to the facility House Supervisors on 3/23/15 that included content from F329, Gradual Dose Reduction requirements and a resource article. A list of diabetic residents with orders for insulin will be obtained and HGB A1C's verified on a monthly basis times three and quarterly times one year. In addition, a comparison review will be completed checking that the facility consultant pharmacists Medication Regimen Reviews have addressed orders for HGB A1Cs in the use of insulin. Summary of the observations will be reviewed at the facility Clinical Quality Improvement meeting. Clinical Director and Consulting Pharmacist are responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/04/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St. Therese Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. St. Therese Home is a 3-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1968 and was determined to be of Type I (332) construction. In 1973, an addition was constructed to the 3rd floor that was determined to be of Type II (111) construction. In 1999, an addition was constructed to the westside of the 1st floor that was determined to be of Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an exiting building, the building is surveyed as one building. The building is fully fire sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 258 beds and had a census of 245 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	03/05/2015

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 2nd, 3rd, 4th and 5th 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R183) reviewed for admission, transfer, and discharge received notification prior to receiving new roommates. Findings include: R183's admission Minimum Data Set (MDS) dated 12/24/14, indicated the resident had no cognitive impairment. During interview on 3/4/15, at 9:33 a.m. family member (FM)-A stated R183 had several new roommates since her admission in December,	2 435	Corrected.	3/27/15

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2 435	Continued From page 3 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 receive advance notice of a roommate change. R183's undated Social Service Admission Information form indicated due to the high demand for placement on the TCU, residents may receive a new roommate the same day the	2 435		

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2 435	Continued From page 4 previous roommate discharges. The facility policy titled Room Change dated 1/13, indicated the social worker will notify the resident currently in the room that they are receiving a new roommate. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could audit resident charts on the transitional care unit for advance notice of roommate changes. The Quality Assurance Committee could discuss and review the audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify, assess, and implement interventions for weight loss for 1 of 3 residents, (R219) reviewed for weight loss. Findings include: R219's quarterly Minimum Data Set (MDS) dated 12/11/14, identified the resident had server	2 965	Corrected	3/26/15

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2 965	Continued From page 5	2 965		

cognitive impairment, required extensive assistance with eating, had no significant weight loss, and was not on a physician prescribed/ planned weight loss program.
R219's current physician orders signed 2/5/15, identified diagnoses including psychosis, dementia, weight loss, and muscle weakness. Her diet order included a regular diet with regular texture and thin liquids. A nutritional supplement of one can of chocolate ensure was ordered once daily, starting 6/18/14, for weight loss per dietary recommendation.
Review of R219's Weights and Vitals Summary from 3/3/14, through 3/4/15, indicated the resident had a gradual weight loss of 16.2% (or 20.5 pounds) over the span of one year, with significant weight loss warnings/alerts beginning on 2/14/15. The following data was included in this summary:
· On 3/3/14, R219's weight was recorded as 126.2 pounds.
· On 4/14/14, her weight was recorded as 124.4 pounds.
· On 5/5/14, her weight was recorded as 120.2 pounds.
· On 6/2/14, her weight was recorded as 118.2 pounds. The summary noted a significant weight loss warning/alert of 11.5% (or 15.4 pounds), compared to a recorded weight of 133.6 pounds on 12/6/13.
[A daily nutritional supplement was initiated on 6/18/14, in response to R219's weight loss.]
· On 7/7/14, her weight was recorded as 119.2 pounds.
· On 8/4/14, her weight was recorded as 119.4 pounds.
· On 9/1/14, her weight was recorded as 117.0 pounds.
· On 10/6/14, her weight was recorded as 117.0 pounds.

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2 965	Continued From page 6	2 965		

· On 12/5/14, her weight was recorded as 116.7 pounds.
· On 1/2/15, her weight was recorded as 116.0 pounds.
· 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.
· On 2/27/15, her weight was recorded as 107.4 pounds. The 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 of 9.4% (or 11.0 pounds) since 12/5/14.

Review of R219's Medication Administration Record (MAR) from 6/18/14, through 3/4/15, indicated the resident consumed an average of 58% of her prescribed nutritional supplement.

Review of R219's quarterly Nutrition Assessment dated 12/11/14, identified no significant weight loss, and directed staff to anticipate her needs related to her diagnosis of dementia. The assessment did not assess R219's food or fluid intakes.

During continuous observation of lunch on 3/4/15, at 12:56 p.m. in the first floor dining room, R219 was asleep while seated in her wheelchair at the dining room table. At 1:09 p.m., R219 remained asleep in her wheelchair, while a tablemate was assisted with eating their meal. At 1:23 p.m., R219's meal was delivered to her, however, she remained asleep in her chair, with no cues or interactions with staff. At 1:26 p.m., Activities (A)-A approached R219 and attempted to wake her up and began to assist her with eating. After a few bites, A-A left to assist another resident back to their room, and registered nurse (RN)-A took

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2 965	Continued From page 7 over feeding R219 until A-A returned at 1:37 p.m. Throughout the meal R219's eyes remained closed, however, she did open her mouth and accept food after most prompts to do so. R219 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.	2 965		

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2 965	Continued From page 8 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 should have been identified between the DM's quarterly nutrition assessments and poor intakes. The DON stated this should have been reported to the dietician either by those who assisted with feeding residents, or via intake documentation sheets. The facility's Significant Weight Loss policy dated 12/10, directed nursing staff to alert the DM if a resident's weight decreased by five pounds or more in the past 30 days. The DM was then responsible for reviewing appetite records and initiating a three day or longer intake record if needed. The DM was also responsible for evaluation of prescribed dietary supplements. The DOM was to inform the assistant director of nursing (ADON) of any new recommendations due to significant weight loss. The policy did not address the process for identification of gradual weight loss. SUGGESTED METHOD OF CORRECTION: The dietician or designee could audit resident charts for unintended weight loss. The dietician could review and revise facility policies and procedures related to weight loss and educate all staff regarding the changes. The Quality Assurance Committee could review audit information to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		4/4/15

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21530	Continued From page 9 A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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	00261	A. BUILDING: _____ B. WING _____	03/05/2015

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21530	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility consultant pharmacist failed to identify the lack of routine lab monitoring for the use of insulin for 1 of 5 residents, (R125) reviewed for unnecessary medications. Findings include: R125's physician orders signed 11/7/14, indicated diagnoses including insulin dependent diabetes. Medication orders included NovoLOG FlexPen Solution, injecting 20 units three times daily, and Levemir FlexPen Solution, injecting 48 units two times daily. Both medications were types of insulin used to maintain adequate control of blood sugars. The physician orders directed lab monitoring for R125's hemoglobin A1C (a blood test used to evaluate control of blood sugars over a period of approximately three months) to be completed on 12/23/14. R125's Medication Administration Record (MAR) from 12/1/14, through 2/28/14, indicated NovoLog and Levemir were routinely administered to R125. R125's medical record indicated the most recent hemoglobin A1C was completed on 5/1/14. During interview on 3/5/15, at 9:10 a.m. registered nurse (RN)-A (R125's clinical care coordinator) reported it was her expectation that hemoglobin A1C labs were to be completed for R125, at the frequency indicated by the physician, which indicated one should have been completed on 12/23/14. RN-A stated the most recent hemoglobin A1C lab completed on R125 was on 5/1/14, and one had not been completed on	21530	Corrected	

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21530	Continued From page 11 12/23/14, as ordered. 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. Pharmacist-A confirmed routine lab monitoring such as this, should have been identified during monthly medication regimen reviews when the pharmacist is 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 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. She stated appropriate/ necessary medication monitoring, including the completion of labs, were to be evaluated by the consultant pharmacist during monthly medication regimen reviews. 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 pharmacist's review. The DON or designee, along with the pharmacist, could audit medication	21530		

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21530	Continued From page 12 reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine lab monitoring for the use of insulin was completed for 1 of 5 residents (R125) reviewed for unnecessary medications.	21540	Corrected	4/4/15

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21540	Continued From page 13 Findings include: R125's physician orders signed 11/7/14, indicated diagnoses including insulin dependent diabetes. Medication orders included NovoLOG FlexPen Solution, injecting 20 units three times daily, and Levemir FlexPen Solution, injecting 48 units two times daily. Both medications were types of insulin used to maintain adequate control of blood sugars. The physician orders directed lab monitoring for R125's hemoglobin A1C (a blood test used to evaluate control of blood sugars over a period of approximately three months) to be completed on 12/23/14. R125's Medication Administration Record (MAR) from 12/1/14, through 2/28/14, indicated NovoLog and Levemir were routinely administered to R125. R125's medical record indicated the most recent hemoglobin A1C was completed on 5/1/14. R125 was observed on 3/4/15, at 12:00 p.m., and on 3/5/15, from 8:27 a.m. to 8:41 a.m., with no signs or symptoms of hypoglycemia, hyperglycemia, or other adverse medication side effects. During interview on 3/5/15, at 9:10 a.m. registered nurse (RN)-A (R125's clinical care coordinator) reported it was her expectation that hemoglobin A1C labs were to be completed for R125, at the frequency indicated by the physician, which indicated one should have been completed on 12/23/14. RN-A stated the most recent hemoglobin A1C lab completed on R125 was on 5/1/14, and one had not been completed on 12/23/14, as ordered.	21540		

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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 the physician, however, they were not tracked by nursing. She stated the facility HUC's were responsible for handling lab orders, ensuring the lab orders were transcribed, put on the calendar to be completed timely, and setting up the lab draw. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place.	21540		

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21540	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		