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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M8G2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 31760

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245630**

2.STATE VENDOR OR MEDICAID NO.
(L2) **091662200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST THERESE TCU NORTH LLC**
(L4) **3300 OAKDALE AVENUE 4TH FLOOR**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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 **07/06/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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
	32			
(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 :
Mary Bruess, HFE NE II — 07/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/09/2017 (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
04/13/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS
Posted 08/15/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/10/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245630
August 9, 2017

Ms. Brooke Hallen, Administrator
St Therese Tcu North Llc
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

Dear Ms. Hallen:

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 June 20, 2017 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

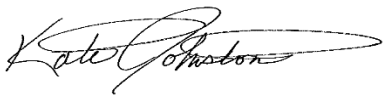
Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 9, 2017

Ms. Brooke Hallen, Administrator
St Therese Tcu North Llc
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

RE: Project Number S5630001

Dear Ms. Hallen:

On June 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 17, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 17, 2017, effective June 20, 2017 and therefore remedies outlined in our letter to you dated June 1, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 9, 2017

Ms. Brooke Hallen, Administrator
St Therese Tcu North Llc
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

Re: Reinspection Results - Project Number S5630001

Dear Ms. Hallen:

On July 6, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 17, 2017. 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M8G2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 31760

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245630**

2. STATE VENDOR OR MEDICAID NO. (L2) **091662200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST THERESE TCU NORTH LLC**
(L4) **3300 OAKDALE AVENUE 4TH FLOOR**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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 **05/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Lisa Hakanson, HFE NE II 06/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/03/2017 (L20)

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

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

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 **04/13/2016** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
06201 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2017

Ms. Brooke Hallen, Administrator
St. Therese TCU North LLC
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

RE: Project Number S5630001

Dear Ms. Hallen:

On May 17, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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 electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233 Fax: (507) 344-2723

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 June 26, 2017, 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 August 17, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 17, 2017 (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.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

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

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
	245630	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE TCU NORTH LLC	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/15, 5/16 and 5/17/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		6/20/17

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

Electronically Signed | 06/08/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245630	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE TCU NORTH LLC	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

(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 323	Continued From page 1 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine if side rails were safe and appropriate for use for 1 of 2 residents (R51) reviewed for side rail safety. Findings include: R51's admission Minimum Data Set (MDS) assessment dated 5/5/17, indicated R51's cognition was severely impaired and needed extensive staff assistance with bed mobility and transfers. R51's profile sheet indicated R51 was admitted on 4/28/17. R51's Care Area Assessment (CAA) dated 5/5/17, indicated R51 was cognitively impaired, had weakness and needed staff assistance with a mechanical lift and for mobility with two staff assistance. R51's care plan dated 4/28/17, indicated R51 had activities of daily living (ADL) deficits related to weakness, needed extensive assist of two staff and recommended bilateral side rails use to increase resident participation. R51's same care plan indicated R51 did not want her side rails up	F 323	Immediate Corrective Action: R1 no longer resides in the facility. Corrective Action as it Applies to Others: The policy and procedure titled: Proper Use of Side Rails was reviewed and remains current. Nursing staff will be re-educated on the policy by 06/20/2017. Current and newly admitted residents or the resident's legal representatives will be interviewed regarding side rail use preference and residents who wish to use side rails as a mobility-aid will be assessed to do so safely, review risks versus benefits and sign an informed consent to use side rails. Additionally, the resident's individual care plan will be updated to reflect the resident's wishes. An audit will be conducted of all beds to ensure side rails are in safe working order. Action to prevent a Recurrence: 3 random weekly audits will be conducted to ensure residents side rails are used in	

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	245630	A. BUILDING _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE TCU NORTH LLC	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

(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 323	Continued From page 2 and was transferred with a Hoyer (mechanical lift) with two staff assistance. R51's nursing assistant (NA) care plan, undated indicated R51 needed extensive assist of two staff for bed mobility and bilateral side rails were recommended to increase resident participation. It also indicated R51 was transferred with stand lift with assist of two staff. On 5/15/17, at 2:44 p.m. R51's bilateral one-quarter (1/4) side rails were observed in the up position; the side rail located on the window side moved back and forth 2-3 inches; the side rail located on the door side moved back and forth 2 inches. On 5/16/17, at 2:56 p.m. R51 was observed sitting in wheelchair (w/c) in room with the window side rail observed in the up position and the door side rail observed in the down position. On 5/16/17, at 2:41 p.m. NA-A stated R51 required two staff to assist with transfer with an EZ stand. NA-A stated R51 could turn a little in bed herself but required staff help with repositioning. NA-A stated R51 would place her hand on the side rail to feel safe. On 5/17/17, at 8:07 a.m. R51 was observed sitting in w/c in room with both side rails in the down position. At 8:58 a.m. NA-B stated R51 needed two staff assistance to help turn/reposition in bed. NA-B stated R51 would try to help and when staff cued, R51 would place hand on the side rail to help reposition. NA-B explained it had not been noted that R51's side rails were loose.	F 323	accordance with facility policy and procedure. 3 weekly preventative maintenance audits will be conducted to ensure beds are maintained in good working order. Audits will be conducted for 90 days and audit results will be shared with the IDT at the quarterly QAPI meeting for input on the need to continue or discontinue auditing. Date Certain: 06/20/2017 Correction will be monitored by: Director of Nursing/Designee	

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F 323	Continued From page 3 On 5/16/17, at 2:44 p.m. licensed practical nurse (LPN)-A stated side rails were by choice and either the resident or the family signed the consent for side rail use on the bed. LPN-A stated this assessment was completed upon admission and was called a "physical device assessment." LPN-A stated when completing this assessment she would go into the resident's room and talk with the resident, pull out the side rail and demonstrate to the resident and explain the importance. The resident would state whether they wanted the rail or not. LPN-A explained if the resident declined , the side rails are tied down. LPN-A stated she received the consent, making sure the resident understood the use. LPN-A stated side rails should not move back and forth, confirming that some rails located throughout the facility did exhibit movement. LPN-A stated side rails should not move as could cause injury and when noted by staff as loose, maintenance would tighten up weekly. LPN-A reiterated the importance of resident safety and would request that maintenance tighten the loose side rail for R51. When interviewed on 5/16/17, at 2:54 p.m. LPN-B stated, "Side rails should be snug when up." Ten minutes later at 3:07 p.m. therapy staff (TS)-A stated during therapy evaluations the resident was assessed for bed mobility safely without side rails or whether they were necessary to promote independence. TS-A also stated therapy would communicate their recommendation to nursing and subsequently, both disciplines would make the final recommendation related to side rail use. At 3:15 p.m. Interim director of nursing (IDON) verified R51's door side rail was in the "down"	F 323		

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F 323	Continued From page 4	F 323		

position and verified the side rail located near the window was in the "up" position and moved back and forth. IDON stated the beds and side rails were measured for possible entrapment and it was okay for side rails to move back and forth.

When interviewed on 5/16/17, at 3:17 p.m. R51 stated she wanted to use the side rails when in bed to help with positioning.

At 3:18 p.m. Interim Assistant DON verified a physical device assessment for side rails not been completed for R51.

On 5/17/17, at 9:05 a.m. LPN-A stated R51 had experienced falls while at home and explained R51 was transferred with an EZ stand. LPN-A stated all resident side rail consents and assessments were received upon admission, as all beds in the facility had side rails. LPN-A stated a consent and assessment should be completed before a resident sleeps in the bed; in addition, residents needed to know how to operate the side rails.

On 5/17/17, at 1:01 p.m. IDON stated the admitting nurse talks to the resident and/or responsible party, reviews side rails risk and benefits, secures a signed consent, and completes the physical device assessment. Upon completion, the side rails were put "up". IDON stated therapy completes an evaluation with the initial screen and recommendations include: removal, add or no side rail. IDON stated a discussion between therapy and nursing occur with a conclusion which should be documented. IDON stated, "Hers [R51's] just got missed."

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F 323	Continued From page 5	F 323		

Review of physical device assessment for R51's recliner dated 4/28/17, indicated, "Pt [R51] want electrical recliner for comfort but declined the side rails" and stated side rails may not be used.

Review of progress note dated 5/16/17, written by IDON at 16:20 indicated, "Spoke with patient [R51] today regarding use of bilateral side rails; patient stated "yes!" when asked if they help her turn on her side in the bed. Explained risks and benefits of the side rails and asked if she would like to use them to which she replied "yes". [R51] was observed during wound rounds using the side rails safely and appropriately. Consent and physical device assessment completed. Care plan reviewed and updated."

On 5/17/17, at 8:24 a.m. housekeeping manager stated after residents are discharged, side rails located on the beds were fastened down and if broken and/or not functioning maintenance would be notified.

When interviewed on 5/16/17, at 3:25 p.m. the administrator (A) stated the maintenance related to side rail repair came to the facility every other Wednesday.

On 5/17/17, at 8:26 a.m. (A) stated all the beds located in the facility had side rails attached and new beds had been requested for purchase.

Policy provided by the facility Proper Use of Side Rails dated December 2016, indicated, "The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids ... An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails ... Consent for using

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F 323	Continued From page 6 restrictive devices will be obtained from the resident or legal representative ... The risks and benefits of side rails will be considered for each resident ..."	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		6/20/17

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F 329	Continued From page 7 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff monitored the effects of the antidepressant (AD) medication for 1 of 5 residents (R48) reviewed for unnecessary medication. Findings include: R48 was observed on 5/16/17, at 11:25 a.m. resting in bed supported by pillows. The room was dark and the window shades pulled shut. R48 voiced no complaints and appeared comfortable. A social history note, dated 4/28/17, indicated R48 was admitted from the hospital following surgery for a right hip fracture. A short term rehab and recovery stay was planned for R48. Upon admission, R48 was prescribed the antidepressants Celexa for depression and Trazadone for sleep. The attending physician noted dated 5/4/17, indicated R48 was having trouble with poor performance in therapy, dehydration, poor appetite, weight loss, and declining functional status. A diagnosis of dementia was discussed with the family. The physician decided to discontinue the Trazadone and start a new antidepressant, Remeron to help improve appetite. The Celexa was also decreased and discontinued.	F 329	Immediate Corrective Action: Resident #48 no longer resides in the facility. Corrective Action as it Applies to Others: The policy and procedure for Behavior/Mood monitoring was reviewed and revised. Nursing staff will be educated on the policy updates by 06/20/2017. Medication orders will be reviewed for other residents who receive antidepressant medications to ensure mood/behavior tracking is established in accordance with the revised policy and procedure. Individualized resident care plans will be reviewed for other residents who receive antidepressant medications for accuracy. Action to Prevent Recurrence: 3 Random Weekly audits will be conducted to ensure residents who receive antidepressant medications have ongoing mood monitoring established according to facility policy. Audits will be conducted for a period of 90 days and audit results will be shared with the IDT at the quarterly QAPI meeting for input on the need to continue or discontinue auditing.	

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F 329	Continued From page 8 The Care Area Assessment (CAA) dated 5/9/17, was completed for R48 related to the use of antidepressants. The CAA summary indicated staff were to observe R48 for any adverse signs and symptoms associated with the medication use. A care plan was to be developed with the objective of helping R48 with symptom relief and managing symptoms. The care plan for R48, dated 4/20/17, indicated the use of antidepressants Celexa and Trazadone. The goal was to be free from discomfort or adverse reactions related to antidepressant therapy. Interventions included: monitor, document and report change in behavior, mood and cognition. The treatment administration record (TAR) directed nursing staff to monitor for expressions of depression: crying, refusing care, or flat affect. Staff were to observe R48 each shift and document "yes" if R48 had expressions of depression and expected to document a progress note describing the identified behavior. Documentation on the TAR from 5/1/17 through 5/16/17, identified a "yes" response 7 times; however, the progress notes lacked further documentation describing the identified expression of depression. On 5/17/17, at 12:31 p.m. the interim director of nursing (IDON) verified documentation related to type of mood and/or behavior was lacking in the record. She further verified this documentation would be important to determine R48's status relative to depression and the response related to initiation of the anti-depressant medication. The IDON stated it has been a facility goal to improve documentation and monitoring of AD medication.	F 329	Date Certain: 06/20/2017 Correction will be monitored by: Director of Nursing/Designee	

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F 329	Continued From page 9 A policy for behavior monitoring was requested but not provided.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 356		6/20/17

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F 356	Continued From page 10 (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure daily and accurate posting of the 24-hour nursing staff posting. This had the potential to affect all 21 residents and visitors in the facility. Findings include: On 5/15/17, at 11:50 a.m. the staff posting was observed at the west nurse's station. The posting was dated 5/13/17, and indicated a census of 20. At 11:58 a.m. there was no posting observed at the West nurse's station. One minute later at 11:59 a.m. the administrator stated the human resources (HR) manager was in the process of printing today's nursing staff posting. On 5/15/17, at 12:05 p.m. the 24 hour posting was observed at the west nurse's station dated "5/16/17" with census left blank. The health unit coordinator (HUC)-A verified the 24 hour posting was dated 5/16/17, (tomorrow's date) and also verified the current census had not been filled in.	F 356	Immediate Corrective action: The correct staffing information was posted once the discrepancy was discovered. Corrective action as it applies to others: The policy and procedure for Posting of staffing hours was reviewed and remains current. Staff will be retrained on the policy by: 06/20/2017 Recurrence will be prevented by: Random weekly audits will be completed to ensure staffing hours are posted in accordance with facility policy and that the posted information is complete and accurate. Audits will be completed for a period of 90 days and the results will be shared with the IDT at the Quarterly QAPI meeting. Date of correction: 06/20/2017	

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F 356	Continued From page 11 HUC-A stated the HR manager was responsible for the posting. On 5/15/17, at 12:15 p.m. the HR manager stated she liked to complete several days of the 24 hour posting in advance and the over night nurse would post the next day's posting after midnight. The HR manager stated she had noted that today (5/15) the 24 hour posting was still dated 5/13, when she printed off the current information. The HR manager stated she had not realized she printed off the 16th today when replacing the posting dated the 13th. The HR manager verified the census was blank and stated, "I build it [the posting] for the staffing piece and leave the census blank expecting the night nurse to fill in the census and changes throughout the day." The HR manager stated she did not know why the night nurse had not changed the 24 hour posting on the 13th or 14th. On 5/15/17, at 12:25 p.m. the 24 hour posting was observed dated 5/15/17, with a handwritten census "21" written on the posting. When interviewed on 5/17/17, at 2:30 p.m. the administrator stated going forward the night nurse would post the daily 24 hour staff posting during the night shift. Policy provided by the facility Transitional Care dated January 2016 indicated, "... Nursing hours will be posted per the regulation for the purpose of communicating hours scheduled with visitors, regulators, and staff ... Posting to include ... Current Census ... The facility must post the nursing staffing on daily basis at beginning of each shift..."	F 356	The correction will be monitored by: Director of Nursing/Designee	

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	245630	A. BUILDING **01 - MAIN** B. WING _____	**05/17/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 17, 2017. At the time of this survey, St. Therese TCU North was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. St Therese TCU North is located on the 4th floor of a 9-story hospital and was determined to be of Type I(332) construction. The facility is fully protected throughout by and automatic fire sprinkler system and has a fire alarm system with smoke detection in corridors, spaces open to the corridors, and patient sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 21 at 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.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2017

Ms. Brooke Hallen, Administrator
St. Therese TCU North LLC
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders - Project Number S5630001

Dear Ms. Hallen:

The above facility was surveyed on May 15, 2017 through May 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact **Kathryn Serie, Unit Supervisor at (507) 476-4233 or at Kathryn.serie@state.mn.us.**

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 contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

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

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
	31760	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE TCU NORTH LLC	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 5/15, 5/16 and 5/17/17, 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		
2 935	MN Rule 4658.0525 Subp. 8 Rehab- Prosthetic Devices Subp. 8. Prosthetic devices. A nursing home must assist residents to adjust to their disabilities and to use their prosthetic devices. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine if side rails were safe and appropriate for use for 1 of 2 residents (R51) reviewed for side rail safety. Findings include: R51's admission Minimum Data Set (MDS) assessment dated 5/5/17, indicated R51's cognition was severely impaired and needed extensive staff assistance with bed mobility and transfers. R51's profile sheet indicated R51 was admitted on 4/28/17. R51's Care Area Assessment (CAA) dated 5/5/17, indicated R51 was cognitively impaired, had weakness and needed staff assistance with a mechanical lift and for mobility with two staff assistance. R51's care plan dated 4/28/17, indicated R51 had activities of daily living (ADL) deficits related to	2 935	Corrected	6/20/17

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2 935	Continued From page 3 weakness, needed extensive assist of two staff and recommended bilateral side rails use to increase resident participation. R51's same care plan indicated R51 did not want her side rails up and was transferred with a Hoyer (mechanical lift) with two staff assistance. R51's nursing assistant (NA) care plan, undated indicated R51 needed extensive assist of two staff for bed mobility and bilateral side rails were recommended to increase resident participation. It also indicated R51 was transferred with stand lift with assist of two staff. On 5/15/17, at 2:44 p.m. R51's bilateral one-quarter (1/4) side rails were observed in the up position; the side rail located on the window side moved back and forth 2-3 inches; the side rail located on the door side moved back and forth 2 inches. On 5/16/17, at 2:56 p.m. R51 was observed sitting in wheelchair (w/c) in room with the window side rail observed in the up position and the door side rail observed in the down position. On 5/16/17, at 2:41 p.m. NA-A stated R51 required two staff to assist with transfer with an EZ stand. NA-A stated R51 could turn a little in bed herself but required staff help with repositioning. NA-A stated R51 would place her hand on the side rail to feel safe. On 5/17/17, at 8:07 a.m. R51 was observed sitting in w/c in room with both side rails in the down position. At 8:58 a.m. NA-B stated R51 needed two staff assistance to help turn/reposition in bed. NA-B stated R51 would try to help and when staff cued,	2 935		

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2 935	Continued From page 4 R51 would place hand on the side rail to help reposition. NA-B explained it had not been noted that R51's side rails were loose. On 5/16/17, at 2:44 p.m. licensed practical nurse (LPN)-A stated side rails were by choice and either the resident or the family signed the consent for side rail use on the bed. LPN-A stated this assessment was completed upon admission and was called a "physical device assessment." LPN-A stated when completing this assessment she would go into the resident's room and talk with the resident, pull out the side rail and demonstrate to the resident and explain the importance. The resident would state whether they wanted the rail or not. LPN-A explained if the resident declined , the side rails are tied down. LPN-A stated she received the consent, making sure the resident understood the use. LPN-A stated side rails should not move back and forth, confirming that some rails located throughout the facility did exhibit movement. LPN-A stated side rails should not move as could cause injury and when noted by staff as loose, maintenance would tighten up weekly. LPN-A reiterated the importance of resident safety and would request that maintenance tighten the loose side rail for R51. When interviewed on 5/16/17, at 2:54 p.m. LPN-B stated, "Side rails should be snug when up." Ten minutes later at 3:07 p.m. therapy staff (TS)-A stated during therapy evaluations the resident was assessed for bed mobility safely without side rails or whether they were necessary to promote independence. TS-A also stated therapy would communicate their recommendation to nursing and subsequently, both disciplines would make the final recommendation related to side rail use.	2 935		

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2 935	Continued From page 5 At 3:15 p.m. Interim director of nursing (IDON) verified R51's door side rail was in the "down" position and verified the side rail located near the window was in the "up" position and moved back and forth. IDON stated the beds and side rails were measured for possible entrapment and it was okay for side rails to move back and forth. When interviewed on 5/16/17, at 3:17 p.m. R51 stated she wanted to use the side rails when in bed to help with positioning. At 3:18 p.m. Interim Assistant DON verified a physical device assessment for side rails not been completed for R51. On 5/17/17, at 9:05 a.m. LPN-A stated R51 had experienced falls while at home and explained R51 was transferred with an EZ stand. LPN-A stated all resident side rail consents and assessments were received upon admission, as all beds in the facility had side rails. LPN-A stated a consent and assessment should be completed before a resident sleeps in the bed; in addition, residents needed to know how to operate the side rails. On 5/17/17, at 1:01 p.m. IDON stated the admitting nurse talks to the resident and/or responsible party, reviews side rails risk and benefits, secures a signed consent, and completes the physical device assessment. Upon completion, the side rails were put "up". IDON stated therapy completes an evaluation with the initial screen and recommendations include: removal, add or no side rail. IDON stated a discussion between therapy and nursing occur with a conclusion which should be documented. IDON stated, "Hers [R51's] just got missed."	2 935		

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2 935	Continued From page 6 Review of physical device assessment for R51's recliner dated 4/28/17, indicated, "Pt [R51] want electrical recliner for comfort but declined the side rails" and stated side rails may not be used. Review of progress note dated 5/16/17, written by IDON at 16:20 indicated, "Spoke with patient [R51] today regarding use of bilateral side rails; patient stated "yes!" when asked if they help her turn on her side in the bed. Explained risks and benefits of the side rails and asked if she would like to use them to which she replied "yes". [R51] was observed during wound rounds using the side rails safely and appropriately. Consent and physical device assessment completed. Care plan reviewed and updated." On 5/17/17, at 8:24 a.m. housekeeping manager stated after residents are discharged, side rails located on the beds were fastened down and if broken and/or not functioning maintenance would be notified. When interviewed on 5/16/17, at 3:25 p.m. the administrator (A) stated the maintenance related to side rail repair came to the facility every other Wednesday. On 5/17/17, at 8:26 a.m. (A) stated all the beds located in the facility had side rails attached and new beds had been requested for purchase. Policy provided by the facility Proper Use of Side Rails dated December 2016, indicated, "The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids ... An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails ... Consent for using	2 935		

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2 935	Continued From page 7 restrictive devices will be obtained from the resident or legal representative ... The risks and benefits of side rails will be considered for each resident ..." SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the importance of an appropriate review of side rail use for all residents and coordinate with therapy for completion of the assessment. A review of the beds located in the facility could be completed to ensure the safe use of side rails. Audits conducted could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 935		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		6/20/17

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21426	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Tuberculosis (TB) monitoring was completed for 5 of 5 residents (R143, R157, R19, R51, R72) and 3 of 5 employees (E1, E2, E4) according to CDC (Centers from Disease Control and Prevention) TB recommendations and the MDH (Minnesota Department of Health) TB Guidelines. Findings include: Review of R143's immunization record (IR) indicated: "TB 3/29/17- 0 mm [millimeters] Neg" and also indicated "TB 5/10/17- 0 mm, Neg". R143's IR did not indicate the dates when tuberculin skin tests (TST) were administered and read as required by TB Guidelines. Review of R157's IR indicated: "TB 4/21/07, 0 mm, Neg" and "TB 5/2/17, 0 mm, Neg" The record did not indicate dates when TST were administered and/or read. Review of R19's IR indicated: "TB 4/29/17, Neg" and "TB 5/14/17, Results Pending". R19's IR did not indicate dates when R19's TST were administered and/or read. Review of R51's IR indicated: "TB step 1-Consent Refused" and "TB 2nd step 2- 5/14/17, Results Pending". R51's IR did not indicate dates when TST administered.	21426	Corrected	

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21426	Continued From page 9 Review of R72's IR indicated: "TB 4/3/17, Neg, 0 mm" and "TB 4/18/17, Neg, 0 mm". On 5/17/17, at 9:32 a.m. the interim assistant director of nursing (IADON) stated she had started three weeks ago and handed the infection control (IC) book. IADON stated she was the IC educator and followed up the end of April. The IADON stated she initiated audits for residents TB monitoring this week. IADON stated the admitting nurse completed the TB Screen and the 1st step TST should be administered 24-48 hours after admission and then read within 48-72 hours after given. IADON stated the 2nd step TST was to be administered 14 days after the 1st step results as long as negative. The IADON stated the mm of induration, results-positive/negative, and date and time should be documented. IADON stated she had not found any follow-up x-ray for R51 completed after the refusal of TST upon admission. IADON stated if a resident refused a TST the nurse should contact the nurse practitioner and/or the on-call physician for direction and document this action. IADON stated she expected R51 to have a 2nd TST completed. The IADON stated that both she and the IDON identified that previously no one had been assigned the responsibility to follow-up on resident immunizations upon admission. She explained they initiated post admission audits related to immunization status. IADON stated the process included: the admission nurse reviews the completion of the immunization consent; the health unit coordinator (HUC) reviews discharge info related to immunization, checks the MN site and alerts the responsible person (yet to be designated in facility). IADON stated half of the residents had been audited but a HUC had incorrectly entered the read date of the TST into PCC (Point Click Care). The IADON stated she	21426		

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21426	Continued From page 10	21426		

had not initiated TST monitoring audits for employees. IADON stated the TST should be documented in PCC with date and time TST administered and date and time of when skin read. IADON verified this had not yet been done.

The IADON verified on R157's May 2017 Medication Administration Record (MAR) R157's 2nd step TST was given on 5/2/17, at 1215 and read on 5/6/17, 1519 four days later, greater than 72 hours, "out of compliance." IADON stated, "It will get changed."

IADON stated R143 was readmitted and TST administered on 4/21/17, at 1530 and read on 4/24/17, at 1550. IADON stated the 2nd step TST was administered on 5/10/17, at 2049 and read on 5/11/17, at 2123; one day too early. She explained the TST was read too early due to the wrong order placed by the HUC and the HUC has now been re-educated.

IADON stated R19 was admitted 4/29/17, staff administered a 1st step TST on 4/29/17 at 1411 and read on 5/1/17, at 1836 and found negative; however, no mm of induration was documented.

IADON stated R72 was admitted on 4/3/17, a TST administered on 4/3/17, at 2130 and read on 4/7/17, at 1812, "greater than 72 hours, I think it is an order entry issue, I will follow up."

IADON stated R51 was admitted on 4/28/17, and an x-ray for TB was not ordered nor completed. IADON stated a nursing progress noted indicated lab was going to be contacted for an x-ray but it had not been completed. IADON verified R51 refused consent for 1st step TST on 4/28/17, but since had agreed so it was administered on 5/14/17, at 1552 and would be read today. She

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21426	Continued From page 11 verified a 1st step TST for R51 had not been completed timely. Review of E1's personnel file (registered nurse) revealed the date of hire (doh) as 3/22/17. The same file revealed E1's TB Screening for TB signs and symptoms and TB history (h/x) was dated 12/20/16, 92 days before date of hire (two days past 90 day guideline). Review of E2's personnel file (nursing assistant) revealed E2's doh was 1/23/17. The same file revealed E2's TB Screening dated 1/18/17; the TB h/x questions had not been answered/completed and dates of positive reaction and past TST had been left blank. Review of E4's personnel file revealed E4's doh was 3/6/17; it identified E4 had a chest x-ray in the past with no copy of the x-ray results filed. On 5/16/17, at 10:44 a.m. the director of nursing (DON) stated the facility did not have a copy of E4's chest x-ray results. DON verified the file just included an X-ray Status Report dated 1/4/16, with a name with no credentials. DON stated the name was a physician assistant and indicated he would attempt to retrieve E4's chest x-ray results. On 5/17/17, at 1:00 p.m. DON provided a copy of E4's chest x-ray results. Policy provided by the facility dated November 2016, Infection Prevention: Tuberculosis (TB) Control Plan indicated, "... Prevention of exposure to TB is the goal, pursued by education, assessment, screening, surveillance, and a written protocol of action... A resident/patient will receive a two-step TST started within 72 hours of admission ... TST results should be documented in millimeters of induration and interpretation recorded." The same policy indicated, "Upon hire,	21426		

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	31760	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE TCU NORTH LLC	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

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21426	Continued From page 12 all employees complete a TB screening." The same policy also indicated, "... If employee/resident/patient refuses a TST, education of the importance and reason should be completed and documented. 2. If the resident/patient/employee continues to refuse after education, then a chest x-ray should be obtained..." Same policy indicated "...Resources: Centers from Disease Control and Prevention (2005) ... Minnesota Department of Health (2014) Regulations from TB Control in Minnesota Health Settings" SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		6/20/17

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21535	Continued From page 13 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff monitored the effects of the antidepressant (AD) medication for 1 of 5 residents (R48) reviewed for unnecessary medication. Findings include: R48 was observed on 5/16/17, at 11:25 a.m. resting in bed supported by pillows. The room was dark and the window shades pulled shut. R48 voiced no complaints and appeared comfortable. A social history note, dated 4/28/17, indicated R48 was admitted from the hospital following surgery for a right hip fracture. A short term rehab and recovery stay was planned for R48. Upon admission, R48 was prescribed the antidepressants Celexa for depression and Trazadone for sleep. The attending physician noted dated 5/4/17, indicated R48 was having	21535	Corrected	

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21535	Continued From page 14	21535		

trouble with poor performance in therapy, dehydration, poor appetite, weight loss, and declining functional status. A diagnosis of dementia was discussed with the family. The physician decided to discontinue the Trazadone and start a new antidepressant, Remeron to help improve appetite. The Celexa was also decreased and discontinued.

The Care Area Assessment (CAA) dated 5/9/17, was completed for R48 related to the use of antidepressants. The CAA summary indicated staff were to observe R48 for any adverse signs and symptoms associated with the medication use. A care plan was to be developed with the objective of helping R48 with symptom relief and managing symptoms.

The care plan for R48, dated 4/20/17, indicated the use of antidepressants Celexa and Trazadone. The goal was to be free from discomfort or adverse reactions related to antidepressant therapy. Interventions included: monitor, document and report change in behavior, mood and cognition.

The treatment administration record (TAR) directed nursing staff to monitor for expressions of depression: crying , refusing care, or flat affect. Staff were to observe R48 each shift and document "yes" if R48 had expressions of depression and expected to document a progress note describing the identified behavior. Documentation on the TAR from 5/1/17 through 5/16/17, identified a "yes" response 7 times; however, the progress notes lacked further documentation describing the identified expression of depression.

On 5/17/17, at 12:31 p.m. the interim director of

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21535	Continued From page 15 nursing (IDON) verified documentation related to type of mood and/or behavior was lacking in the record. She further verified this documentation would be important to determine R48's status relative to depression and the response related to initiation of the anti-depressant medication. The IDON stated it has been a facility goal to improve documentation and monitoring of AD medication. A policy for behavior monitoring was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could assure polices and procedures are current, implemented and monitored to assure nursing staff are identifying target behaviors and completing documentation. Audits could be completed and reported to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		