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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: POR2

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 **05/14/2014** (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:
X 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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A,5*** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor — 05/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 05/30/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5518
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 - corridor as plenum was previously forwarded. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page. Effective 5/9/2014, the facility is certified for 258 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245518

May 15, 2014

Ms. Barbara Rode, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, Minnesota 55428

Dear Ms. Rode:

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. This facility's request for an annual waiver for K67 has been approved.

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 May 9, 2014, the above facility is certified 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.

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

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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 15, 2014

Ms. Barbara Rode, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, Minnesota 55428

RE: Project Number S5518024

Dear Ms. Rode:

On April 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 5, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective NO DATA and therefore remedies outlined in our letter to you dated April 17, 2014, 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
Licensing and Certification Program
Division of Compliance Monitoring
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	5/14/2014

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **04/07/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/09/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/09/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/30/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/25/2014**	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	5/15/2014	29249	5/14/2014
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?
4/3/2014	YES NO

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 01 - MAIN BUILDING 01	5/5/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0012	05/02/2014	ID Prefix Reg. # NFPA 101 LSC K0056	05/02/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	5/15/2014	27200	5/5/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: POR2

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 **04/03/2014** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B ,5** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
LoAnne DeGagne, HFE NE II — 04/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 05/30/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5518
Item 16 Continuation for CMS-1539

At the time of the standard survey completed April 3, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. The facility's request for a continuing waiver involving the deficiency cited at K67 was previously forwarded. Approval of the waiver request was recommended. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 17, 2014

Ms. Barbara Rode, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, Minnesota 55428

RE: Project Number S5518024

Dear Ms. Rode:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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:

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:

Brenda Fischer, Supervisor
St. Cloud Survey Team A
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: brenda.fischer@state.mn.us

Phone: (320) 223-7338
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 May 13, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 13, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 3, 2014 (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 October 3, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5518S14EPOC.RTF

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 _____	04/03/2014

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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		4/7/14

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

Electronically Signed | 04/25/2014

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
	245518	A. BUILDING _____ B. WING _____	04/03/2014

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 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure information regarding resident rights, Medicaid eligibility, complaint processes and contact information for resident advocacy groups were posted in prominent areas for all residents, families and visitors to reference. This had the potential to affect all 249 of 249 residents who resided in the facility. Findings include: During initial tour observations on 3/31/14, at 1:00 p.m. postings for the Resident Bill of Rights, Medicaid eligibility requirements, state agency contact information for complaints and ombudsman contact information for advocacy support were unable to be located within the facility.	F 156	The Resident Bill of Rights was re-posted on 3/31/14 immediately upon finding the document had not been re-posted upon completion of a construction project. All residents had the potential to be affected by the practice. The facility construction project has since been completed in the area the Resident Bill of Rights posting. Resident Bill of Rights posting will be verified monthly times three and quarterly times one year. Findings will be reported at quarterly facility clinical quality improvement meetings.	

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F 156	Continued From page 3 During interview on 3/31/14, at 1:45 p.m. the director of nursing (DON) and social services (SS)-A verified these information postings were not currently displayed anywhere within the facility. DON and SS-A reported that they had just checked the location where the postings were displayed in the past and noticed they were not there anymore. They added that the postings were taken down during a remodeling project, but were not reposted upon completion. During interview on 4/3/14, at 9:35 a.m. DON estimated the postings were taken down around late Fall, 2013, for the facility's remodeling project.	F 156		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 1 of 1 resident (R296) who was receiving dialysis treatment. Findings include: R296 admitted to the facility 3/14/14, with diagnosis that included end stage renal disease, hyperpotassemia, and anemia in chronic kidney disease as indicated on the medication	F 282	Resident was alert and orientated and had managed his dialysis services independently prior to admission to Transitional Care Unit on 3/14/14. Resident transitional unit plan of care included the fluid restriction intervention. The nursing assistant care guide was corrected at the time of the finding on 4/2/14 to include the fluid restriction. Resident discharged to home on 4/2/14. RN Coordinator responsible for placing	5/9/14

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F 282	Continued From page 4 administration record (MAR). The admission minimum data set (MDS) dated 3/21/14, indicated R296 was cognitively intact. The temporary plan of care last reviewed 3/26/14, noted R296 to be on a 1500 milliliter (ml) fluid restriction per day. The medication administration record (MAR) for April 2014, noted R296 received nutritional supplement per dietary recommendation, one time per day in the amount of 240 ml, the fluid restriction of 1500 ml per day distribution for nursing of 200 ml per shift, and the 240 ml for the nutritional supplement, and facility to transport to dialysis and family to transport back to the facility. The nursing assistant (NA) care guide made no mention of a fluid restriction. Nurse Practitioner note dated 3/17/14, noted "Nephrology consult felt patient overloaded which may have contributed to generalized weakness and fatigue." It also noted "He had just returned from hemodialysis and discharge summary notes orthostatic hypotension after dialysis during hospital stay." When interviewed on 4/2/14, at 12:55 p.m. nursing assistant (NA)-A stated she was unaware of any special instructions for R296 related to fluids. When interviewed on 4/2/14, at 1:00 p.m. NA-B verified she had passed the water to residents this shift, and indicated she forgot about his fluid restriction.	F 282	the fluid restriction intervention on the nursing assistant care guide was verbally educated on 4/2/14. There were no further dialysis residents in the facility. The facility drafted a policy addressing the practice of Nursing Assistant Care guides and shift report on 4/25/14 which included revisions to the facility nursing assistant care guide and report process. Facility will educate licensed nurses the week of 4/28/14 on policy and process and nursing assistants at the Nursing Assistant skills fair April 29th, 30th and May 1st, 2014. Implementation of the revised NAR care guide and report process will begin on 5/1/14 and will be completed by 5/09/14. The facility will complete nursing assistant care guide observations monthly times three and quarterly times one year. Findings will be reported at the facility clinical practice quarterly meetings. The Clinical Director or Nursing is responsible for compliance.	

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F 282	Continued From page 5 When interviewed on 4/3/14, at 11:00 a.m. director of nursing (DON) indicated a fluid restriction would be communicated to the NAs through daily report. She also indicated there should be communication returning back from the dialysis facility. She verified the facility should be following up and seeing if any communication is returned with the patient post treatment.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide monitoring for fluid restriction for 1 of 1 resident (R296) who required dialysis treatments three times per week for renal (kidney) failure. The facility also failed to assure communication occurred between the dialysis facility and the nursing home. Findings include: R296 admitted to the facility 3/14/14, with diagnosis that included end stage renal disease, hyperpotassemia, and anemia in chronic kidney disease as indicated on the medication administration record (MAR).	F 309	Resident was alert and orientated and had managed his dialysis services independently prior to admission to Transitional Care Unit on 3/14/14. Resident transitional care unit plan of care included the fluid restriction intervention. The nursing assistant care guide was corrected at the time of the finding on 4/2/14 to include the fluid restriction intervention. Resident discharged to home on 4/2/14. RN Coordinator responsible for placing the fluid restriction intervention on the nursing assistant care guide was verbally educated on 4/2/14. There were no further dialysis residents in the facility. The facility drafted a policy	5/9/14

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F 309	Continued From page 6 The admission minimum data set (MDS) dated 3/21/14, indicated R296 was cognitively intact. The temporary plan of care last reviewed 3/26/14, noted R296 to be on a 1500 milliliter (ml) fluid restriction per day. The medication administration record (MAR) for April 2014, noted R296 received nutritional supplement per dietary recommendation one time a day in the amount of 240 ml, the fluid restriction of 1500 ml per day distribution for nursing of 200 ml per shift, and the 240 ml for the nutritional supplement, and facility to transport to dialysis and family to transport back to the facility. The nursing assistant (NA) care guide made no mention of a fluid restriction. Nurse Practitioner note dated 3/17/14, noted "Nephrology consult felt patient overloaded which may have contributed to generalized weakness and fatigue." It also noted "He had just returned from hemodialysis and discharge summary notes orthostatic hypotension after dialysis during hospital stay." Nursing note dated 3/18/14, noted "Call placed to DaVita Dialysis Minnetonka location. Inquired as to any medication alterations in adm on Dialysis days. Also to request any labs/results that were drawn at dialysis to be sent back to facility for our records." When interviewed on 4/2/14, at 12:17 p.m. registered nurse (RN)-A denied sending any communication along with R296 to his dialysis treatments. When interviewed on 4/2/14, at 12:25 p.m. RN-B	F 309	addressing the practice of Nursing Assistant Care guides and shift report on 4/25/14 which included revisions to the facility nursing assistant care guide and report process. Facility will educate licensed nurses the week of 4/28/14 on new policy and nursing assistants at the Nursing Assistant skills fair April 29th, 30th and May 1st, 2014. Implementation of the revised NAR care guide and report process will begin on 5/1/14 and will be completed by 5/09/14. The facility dialysis inter-agency communication form sent with the resident to dialysis runs was revised on 4/9/14. The facility adopted a dialysis care plan template reflective of QIS survey dialysis regulatory requirements on 4/9/14. Both new forms are ready for implementation when the facility admits a resident requiring dialysis needs. Nursing Administration was educated on both new forms on 4/23/14. Education will be completed by 5/2/14 to TCU licensed nurses on Dialysis policy that will include inter-agency dialysis communication form and dialysis care plan template. The facility will complete nursing assistant care guide observations monthly times three and quarterly times one year. If facility admits resident with dialysis, observations will be completed to ensure interagency communication dialysis forms are being sent with resident and returned after dialysis run as well as use of the dialysis care plan template. Findings will be reported at the facility clinical practice quarterly meetings. The Clinical Director or Nursing is responsible for compliance.	

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indicated paperwork of a consult form is sent with each time R296 goes to dialysis. She indicated the dialysis facility will occasionally send back the weight and how the run went. She was unable to locate any such documentation in R296's chart. She indicated it would not be necessary to have the fluid restriction on the NA care guide.

When interviewed on 4/2/14, at 12:48 p.m. RN-C, who was the clinical manager verified a pink water pitcher was noted in R296's room which was 3/4 full. She noted at this time no water pitcher should be in the room, and she would add it to the NA care guide. At this time assistant director of nursing (ADON) also verified there should be no water pitcher in R296's room, and this should be added to the NA care guide.

When interviewed on 4/2/14, at 12:55 p.m. nursing assistant (NA)-A stated indicated she was unaware of any special instruction on R296 related to a fluid restriction.

When interviewed on 4/2/14, at 1:00 p.m. NA-B verified she had passed the water to residents this shift, and indicated she forgot about his fluid restriction.

When interviewed on 4/3/14, at 9:27 a.m. assistant director and nursing and RN-C both identified they had been unable to locate any documentation in the chart from the dialysis facility post treatment to see how R296 tolerated the treatments.

When interviewed on 4/3/14, at 9:43 a.m. registered dietitian (RD)-X, a dietician at the dialysis center where R296 had his treatments stated, R296 comes to the dialysis center with

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F 309	Continued From page 8 paperwork, which is sent back with the resident post treatment. When interviewed on 4/3/14, at 11:00 a.m. director of nursing (DON) indicated a fluid restriction would be communicated to the NAs through daily report. She also indicated there should be communication returning back from the dialysis facility. She verified the facility should be following up and seeing if any communication is returned with the patient post treatment. Facility policy titled Dialysis - Care of Residents with Hemodialysis dated May 2013, indicated "Upon return from the dialysis treatment, any recommendations or orders will be transcribed per facility policy and any concerns relayed to the resident's MD [medical doctor]/ NP [nurse practitioner] as needed."	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356		4/30/14

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F 356	Continued From page 9 of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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 the nursing hours posting detailed the actual hours (shift times) worked, separated into categories of registered nurses, licensed practical nurses, nursing assistants and trained medication aides. The posting also failed to identify the total resident census. This had the potential to affect 249 of 249 residents who resided in the facility, along with family and visitors. Findings include: During initial tour observations on 3/31/14, at 1:00 p.m. the facility's nursing hours posting was noted to lack some of the required components. Further review of the Report of Nursing Staff Hours Directly Responsible for Resident Care dated 3/31/14, and review of the subsequent nursing hours postings dated 4/1/14, 4/2/14, and 4/3/14, revealed the following:	F 356	Based on interview and document review the facility failed to ensure the posting of total resident census of all units added together, the number of hours worked by day/evening/night shift separated by unit and the nursing hours separated into categories of registered nurses, licensed practical nurses, nursing assistants and trained medication aides by shift worked. The facility process was reviewed, policy and staffing posting forms updated to meet regulation on and corrected on 4/25/14. The practice had the potential to affect all residents. Training on the new process and policy will be completed for House Supervisors, Nursing Administration and Staffing Office by 4/30/14 Observations of staffing hours postings will be completed monthly times three and quarterly thereafter times one year. Findings will be reported at the facility clinical practice meetings. Clinical	

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F 356	Continued From page 10 - The number of hours worked by day/evening/overnight shift, separated by each unit and separated by licensed and unlicensed staff. - The total number of hours worked for the shift, separated by licensed and unlicensed staff. - The number of hours scheduled by staff for the shift, separated by each unit and separated by licensed and unlicensed staff. - The resident census for each unit of the facility. The postings lacked the actual shift times that were worked and the number of hours worked during each of those shift times, separated by registered nurses, licensed practical nurses and nursing assistants. The posting also lacked the total resident census of all units added together. During interview on 4/3/14, at 11:15 a.m. the facility's staffing coordinator (SC) and associate director of nursing (ADON)-C verified they were responsible for completion of the facility's nursing hours posting. SC and ADON-C reported they were unaware the current nursing hours report format was not in compliance with the required components.	F 356	Director is responsible for compliance.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	On 4/3/14, the towel found to be wrapped	4/25/14

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F 465	Continued From page 11 review, the facility did not ensure clean and sanitized surface areas in a shared bathroom, related to a soiled towel that was wrapped around a pipe along the back of a toilet seat, for 2 of 2 residents (R372 and R285) who utilized the shared bathroom. Findings include: R372's significant change minimum data set (MDS) dated 3/13/14, revealed she had moderately impaired cognition, required extensive assistance for toileting, was occasionally incontinent of urine. R285's admission MDS dated 3/3/14, revealed she was cognitively intact, required extensive assistance for toileting and was occasionally incontinent of urine. During observation on 4/1/14, at 9:21 a.m. the shared bathroom of R372 and R285 was noted with a white towel wrapped around a pipe that rose up from the back of the toilet seat. The bottom portion of the towel was observed to rest along the surface of the toilet bowl, just behind the seat. The towel appeared to be clean at this time. During interview on 4/2/14, at 11:30 a.m. R372 verified there was a towel wrapped around the pipe behind the toilet seat. She reported that the towel had been there for as long as she could remember, but she did not know why it was there. During observation and interview on 4/3/14, R285 was assisted to use the toilet by nursing assistant (NA)-G. When R285 was seated on the toilet, her bare upper buttocks and lower back were in	F 465	around pipe that rose from the back of the toilet seat was removed. The towel was determined to have no bearing on the current resident□s functional use of the bathroom. A whole house observation was completed on 4/10/14 and no further towels were noted to be placed around bathroom pipes. On 4/21/14 the nursing assistant tool used to monitor performance was updated to include a check of the bathroom pipes and remove towels if noted in use. Housekeeping education was completed on 4/25/14. Content of education included removal of towels if noted on the toilet pipes and Restroom Daily Maintenance policy which was updated on 4/22/14 to reflect this practice. Communication to licensed staff instructed staff to consult Occupational/Physical Therapy if a resident is assessed to potentially benefit from a therapy evaluation for toilet positioning. Observations of resident bathrooms will be completed monthly times three and quarterly thereafter times one year. Findings will be communicated at the facility Clinical Practice meetings. Clinical Director and Director of Housekeeping will be responsible for compliance.	

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F 465	Continued From page 12	F 465		

contact with the towel. NA-G verified the towel was wrapped around the pipe behind the toilet seat. She did not know what the purpose of the towel was, but thought one of the residents might have requested it. NA-G reported that she believed that housekeeping changed the towel routinely to ensure it was clean.

During the environmental tour on 4/3/14, at 9:45 a.m. with maintenance (M)-A and plant manager (PM), the shared bathroom of R372 and R285 was observed. M-A and PM both verified a towel was wrapped around the pipe behind the toilet seat. During this observation, the towel was noted to be soiled, with some light yellow spots and a light blue streak that appeared to be a toilet bowl cleaning solution. M-A and PM were not aware of why a towel was wrapped around the pipe, but both agreed it should not have been there. M-A and PM reported that if there was a problem with the pipe, it should have been reported to maintenance for repair. The towel was again noted in a position that could have rested against a resident's buttock/back of a resident who used the toilet.

Review of the facility's Restroom, Daily Maintenance policy dated 4/2/12, instructed a clean, orderly and attractive environment that prevented the spread of infection was to be maintained within facility restrooms. The procedure included, "Spray disinfectant cleaner on a cloth and clean all toilet seats, flush handles, exposed pipes, and outside surfaces of the toilets and urinals."

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 _____	**04/02/2014**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Therese Home was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2014

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
	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St. 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. Due to the K56 tag, the facility has been determined to be partially fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that and the facility is monitored for automatic fire department notification. The facility	K 000		

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2014**

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	Continued From page 2 has a capacity of 258 beds and had a census of 252 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility's construction type does not meet the requirements of NFPA 101, Life safety Code (00) section 19.1.6. due to the facility being partially fire sprinkler protected. This deficient condition will decrease the facility's structural protection capabilities in the event of an emergency and could affect 252 of 252 residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 4:30 PM on 04/02/2014, observations reveled that the facility is a 3 story building with no basement that was built at four different time and of two different construction types. The 1968 building and the 1999 and 2003 additions were determined to be Type I (332) construction and the 1973 addition was determined to be of Type II (111) construction. Due to the dissimilar construction types, the facility was downgraded to a Type II (111) construction Type. It was also determined	K 012	This deficiency will be corrected at the time of the K056 completion which will be on or before May 2nd. Rick Campbell,Plant Operations Manager will be responsible for the correction and monitoring.	5/2/14

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K 012	Continued From page 3 that the penthouse that is accessible from the 3rd floor is not fire sprinkler protected. The facility, being a 3-story Type II (111) building and has been determined to be partially fire sprinkler protected, does not meet the minimum requirements of type, height, and sprinkler protection status in accordance with the NFPA 101 Life Safety Code (00), section 19.1.6.2 as outlined in table 19.1.6.2. This deficient practice was confirmed by the Plant Operations supervisor (CK) at the time of discovery.	K 012		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility's automatic fire sprinkler system is not installed and maintained in accordance with NFPA 101 Life Safety Code,	K 056	Viking Sprinkler will install the Fire Sprinkler system in the Penthouse in accordance with NFPA 13. This will make the facility fully Fire Sprinkler protected.	5/2/14

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K 056	Continued From page 4 (00), NFPA 13 the Standard for the Installation of Sprinkler Systems (99) and CMS S&C-13-55-LSC. This deficient condition will decrease the facility's fire protection system capabilities in the event of an emergency and could affect 112 of 252 residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 4:30 PM on 04/02/2014, observations reveled that the facility has a penthouse that is accessible from the 3rd floor. This penthouse contains facility air handling equipment, chillers, various pieces of maintenance equipment, and it also provides access to the elevator cable systems and access to the tops of the elevator shafts. It was found that the facility's penthouse was not fire sprinkler protected at the time of the inspection. As per CMS S&C-13-55-LSC this deficient condition will cause the facility to be downgraded from being fully fire sprinkler protected to a status of being partially fire sprinkler protected. This deficient practice was confirmed by the Plant Operations supervisor (CK) at the time of discovery.	K 056	The completion date will be on or before May 2nd 2014. Rick Campbell, Plant Operations Manager will be responsible for the correction and monitoring.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		5/2/14

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 _____	**04/02/2014**

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K 067	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect 140 of 252 residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 9:30 AM to 4:30 PM on 04/02/2014, observations revealed that the heating, ventilation, and air conditioning systems for the first and second floor of the 1968 building are using the corridor system as part of the air distribution system for make-up air for the bathrooms exhaust. This does not meet Exception 2 of NFPA 90A (1999 edition), Section 2-3.11.1 that allows over-pressurized corridors. This deficient practice was confirmed by the Plant Operations supervisor (CK) at the time of discovery.	K 067	Request for Annual Plenum Waiver (see attached addendum and hardship letter). Rick Campbell, Plant Operations Manager will be responsible for the correction and monitoring.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
April 17, 2014

Ms. Barbara Rode, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, Minnesota 55428

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5518024

Dear Ms. Rode:

The above facility was surveyed on March 31, 2014 through April 3, 2014 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 Brenda Fischer at (320) 223-7338 or email at: brenda.fischer@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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, April 29, 2014 9:57 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: robert.rexeisen@state.mn.us; 'deniseb@sttheresemn.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: St Therese Home (245518) K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that St Therese Home is again requesting an annual waiver for K67, corridors as a plenum. The exit date was on or about 4-2-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility **2000 CODE**

St. Therese Home, Inc. 8000 Bass Lake Road, New Hope, MN 55428

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum 1 of 2	A) A continuing waiver is being requested for K-067. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: • The most cost estimate for complying HVAC system dated 4/8/2014 is $1,000,000.00. Financing costs @ 5% add an additional $272,768.00 to the project. • Under the current reimbursement rates, we estimate that it take up to 50 years to recoup the project costs. • The installation and construction work of the new ventilation system would also severely impact the resident's ability to move about the facility and affect their quality of life with the construction noise, dust and obstructions. • The building design with a fixed, solid corridor ceilings limits installation options because of inadequate `head room' that would result in adding ducting. The current ceiling height is 8 feet, the addition of ducts and ceiling materials would reduce the head room to less than 6 foot 5 inches. • The building is current 46 years old and is slated for replacement in 2032 B) There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because: • St. Therese Home is a 3 level, Type `II' building structure with interior finish ratings for: flame 20 & smoke 85 on the 1st floor -flame 25 and smoke 45 on the 2nd floor --flame 15 and smoke 30 on the 3rd floor. • The walls, floors, ceilings and vertical openings were designed & constructed to resist the passage of smoke.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-29-14

Name of Facility **2000 CODE**

St. Therese Home, Inc. 8000 Bass Lake Road, New Hope, MN 55428

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) does not comply with LSC (00) Section 9.2 and NFPA90A, 1999 Ed., because the corridors are being used as a plenum 2 of 2	B) • There are 3 smoke compartments on each floor of the facility. • Training for staff on the facility compliant `Fire Safety Plan' is conducted annually. • The facility will be fully sprinkled as of May 2, 2014 with the K056 correction of sprinklers in the penthouse. • A "Fire Watch" procedure is implemented whenever the fire alarm or fire sprinkler system is down for maintenance, repair or upgrades. The Plant Operations Supervisor has been designated and trained for conducting the fire watch procedure when necessary. Documentation of fire watch rounds are available for review. • The fire department station is 2 miles away and has an average of a 3 minute response time. • The fire alarm systems (pull stations, smoke /heat detection & notification devices) have been updated to include `addressable' technology throughout. • Monthly fire drills are conducted and documented on all 3 shifts for staff. • The facility is inspected annually by a deputy from the Minnesota Fire Marshall office. • The facility staffing ratio is 1 staff per 1.3 residents in a 24 hour period.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date

UHL COMPANY
www.uhlcompany.com
763 • 425 • 7226
9065 ZACHARY LANE N
MAPLE GROVE, MN 55369

April 8, 2014

St Therese
8000 Bass Lake Road
New Hope, MN 55428

Attention: Rick Campbell

Dear Rick:

This letter is regarding costs to install return air ducts for the floors in the Care Center.

First, there is no place to install these return air ducts without major building modifications. I believe the sheet metal work, (return air ducts), could cost in excess of $400,000.00 and the contracted cost to modify the building, to install the return air duct work could cost in excess of $1,000,000.00.

In conclusion, I do not feel this project is feasible.

Sincerely,
Uhl Company, Inc.

Roy H. Jensen
Account Manager