DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 21, 2023

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

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On June 23, 2023, we informed you of imposed enforcement remedies.

On July 27, 2023, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility 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), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 13, 2023, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 13, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 23, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from

September 13, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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).

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900

Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 December 13, 2023 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://mdhprovidercontent.web.health.state.mn.us/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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

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

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August 21, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: SXEC11

Dear Administrator:

The above facility was surveyed on July 24, 2023 through July 27, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/24/23 through 7/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/24/23 through 7/27/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56323944C (MN00095287), H56323866C (MN00087602), H56323864C (MN00087644), H56323868C (MN00083622), H56323869C (MN00095125), H56323992C (MN00084673), H56323993C (MN00091738), H56323865C (MN00087801), H56323867C (MN00090198). 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 onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 08/31/2023

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

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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		9/21/23

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F 578	Continued From page 2 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in all areas of the medical record for 1 of 22 residents (R33) reviewed for advanced directives. Findings include: R33's five-day Minimum Data Set dated 6/28/23, indicated moderate cognitive impairment and required extensive assist for most activities of daily living (ADLs). R33's Medical Diagnosis form in the electronic health record (EHR), indicated the following diagnoses: unspecified fracture of left femur, unspecified fracture of unspecified metacarpal bone, fracture of orbital floor, type two diabetes mellitus, unspecified fracture of facial bones, anemia in chronic kidney disease, chronic kidney disease stage four, malignant neoplasm of unspecified site of left female breast, age related osteoporosis with current pathological fracture. R33's progress note dated 6/22/23, indicated R33 was alert. R33's progress note dated 7/1/23, indicated R33 was alert and oriented. R33's medication administration profile printed	F 578	578 – Immediate corrective action: POLST and PCC updated to reflect accurate Code Status for resident involved. Corrective action to address potential residents affected: All house audit for POLST and PCC congruency completed. Actions taken to reduce potential for reoccurrence: Policy and procedure for advanced directives and POLST have been reviewed. IDT educated on the policy and procedures. Nursing department educated on POLST procedure and order entry for consistency. How will corrections be monitored: Weekly audits of 5 residents for 1 month, followed by monthly audits for 3 months; followed by quarterly audits for 6 months. Findings to be presented at Quality Assurance and Review. Monitoring will be done by Director of Nursing and/or designee.	

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F 578	Continued From page 3 7/24/23, next to heading, Advance Directive indicated R33 wanted full treatment. R33's Clinical Census form in the EHR, indicated R33 wanted full treatment under the heading, Code Status. R33's physician orders dated 6/26/23, indicated R33 wanted full treatment. R33's physician orders for life sustaining treatment (POLST) dated 6/26/23, indicated R33 did not want resuscitation attempted. During interview on 7/24/23 at 7:16 p.m., registered nurse (RN)-A stated she looked on the computer or in the paper chart to find a resident's code status. During interview on 7/24/23 at 7:22 p.m., R33 stated she did not want cardiopulmonary resuscitation (CPR). During interview on 7/24/23 at 7:25 p.m., RN-B stated she looked at the medication administration record or checked the POLST in order to determine a resident's code status and stated they would call the physician if the code status didn't match. During interview on 7/24/23 at 7:31 p.m., RN-A stated she would perform CPR if a resident's heart stopped and there was a discrepancy in the medical record. During interview on 7/24/23 at 7:45 p.m., RN-B stated she would perform CPR if there was a discrepancy with the code status in EHR and in the paper chart.	F 578		

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F 578	Continued From page 4 During interview on 7/25/23 at 8:16 a.m., licensed practical nurse (LPN)-C stated she would look at the banner in the EHR to determine a resident's code status, and if she was not by the computer, LPN-C would look at the POLST in the paper chart. LPN-C further stated she would start CPR right away if she was not sure about a resident's code status. During interview on 7/25/23 at 9:02 a.m., the director of nursing (DON) stated the code status was found either in the paper chart or in the EHR on the banner. DON verified the banner in the EHR indicated R33 wanted full treatment and stated full treatment meant they would perform CPR on R33. At 9:14 a.m., DON verified R33's POLST indicated she did not want CPR. DON further stated code status discrepancies in a resident's medical record was a big risk because they might perform CPR, and the resident may not want CPR, or vice versa. DON verified physician orders dated 6/26/23, indicated full code status, contrary to R33's POLST which indicated R33 did not want CPR. A policy, Communication of Code Status dated 4/1/22, indicated it was the policy of the facility to adhere to residents' rights to formulate advance directives. When an order is written pertaining to a resident's presence or absence of an advance directive, the directions would be clearly documented in designated sections of the medical record. Examples of directions to be documented include full code, do not resuscitate, do not intubate, do not hospitalize. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. There was a section in the	F 578		

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F 578	Continued From page 5 policy to identify the designated sections of the medical record, however the designated sections were not identified in the policy.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement physician's orders for dressing changes as written for 2 of 2 residents (R26 and R205) reviewed for dressing changes. Findings include: R26's admission Minimum Data Set (MDS) dated 6/27/23, identified intact cognition, extensive staff assistance needed for dressing, limited staff assistance needed for hygiene, and diagnoses of bloodstream infection and heart failure. R26 received antibiotics seven out of seven days in the lookback period, and received IV medications before admission and while a resident. R26's Treatment Administration Record (TAR) dated 7/1/23 through 7/26/23, identified an order to change Peripherally Inserted Central Catheter (PICC - a long tube inserted into the arm which	F 684	The wound care order was immediately clarified and updated for clear directives. The resident was seen by physician per routine appointment and report of no regression of wound notes post appointment. PICC dressing was changed immediately upon notification from survey team of past due dressing change. No adverse effects noted at PICC insertion site. The facility has determined that all residents with PICC lines or wound care dressings have the potential to be affected. A physician order review was completed for all residents receiving IV meds per PICC line and all residents with wound care dressings to ensure dressing changes as per physician orders and observations of dressings completed.	9/21/23

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F 684	Continued From page 6 leads to the heart to allow direct administration of intravenous medications) dressing every Sunday. The dressing change was initialed completed on 7/16/23 and 7/23/23. The dressing was due next on 7/30/23. During an observation and interview on 7/24/23 at 12:57 p.m., R26 stated she had sepsis (bloodstream infection) before her admission and was at the facility for rehab and intravenous (IV) antibiotics. R26 had IV antibiotics infusing continuously. R26 stated it had been "a while" since her PICC dressing was changed and was not sure how often it needed to be changed. R26's PICC dressing had a transparent window with gauze border which allowed visualization of the access site. R26's PICC dressing had a written date on it of 7/16/23. R26's PICC dressing was not changed on 7/23/23, as ordered and was now one day overdue. During an observation and interview on 7/27/23 at 8:33 a.m., registered nurse (RN)-D looked at R26's PICC site and verified the dressing was last changed on 7/16/23, not on 7/23/23, as ordered and was now four days overdue. RN-D stated the standard was to change weekly, if dressings were not changed weekly then the risk of infection would be increased. RN-D verified the transparent window of the dressing had visible condensation and should be changed today. During an observation and interview on 7/27/23 at 9:10 a.m., the director of nursing (DON) entered R26's room, verified the PICC dressing was dated 7/16/23, past due, and stated it should have been changed once weekly to reduce the risk of infection.	F 684	All licensed staff were in-serviced/educated regarding the facility policy for physician order clarification and completion of PICC/Dressing changes per eMAR and documentation. Education was provided by DON. Additionally, the nurse manager or designee will conduct weekly audit/oversight of wound dressings and PICC dressings to ensure dressing changes were completed as per physician orders. Audit records will be reviewed monthly at QAPI such time consistent substantial compliance has been achieved as determined by the committee.	

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	245632	A. BUILDING _____ B. WING _____	C 07/27/2023

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F 684	Continued From page 7 During an interview on 7/27/23 at 10:00 a.m., RN-C stated she worked with R26 on 7/23/23, and had initialed the task as completed on the TAR but had not completed the PICC dressing change. RN-C stated it was a "major" omission on her part. The facility policy titled PICC Dressing Change dated 4/1/22, identified PICC dressings were changed weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders would specify the type of dressing and frequency of changes. R205's face sheet (undated) included diagnoses of type 2 diabetes mellitus with foot ulcer, cutaneous abscess of unspecified foot, and streptococcal infection of unspecified site. R205's physician's orders dated 7/22/23, included wound to left plantar midfoot. Keep dressing clean, dry, and intact until you're seen in clinic. Change dressing daily with dry gauze, kerlix, all cotton elastic (ACE) bandage. Keep dressing dry. If you notice drainage through dressing or if dressing becomes wet call the clinic, dressing change every day shift for wound care. R205's progress note dated 7/24/2023, indicated daily condition documentation: surgical/wound care. -location of surgical incision or wound: diabetic foot wounds on left lower extremity. -dressing Change: dressing should stay intact until next follow-up appointment. -sign/symptoms of Infection: drainage noted -level of pain and response to pain medication: patient complains of headache this morning. 500mg Tylenol administered per request.	F 684		

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F 684	Continued From page 8 -participation in Therapy: PT/OT -lab results: not within normal limits -vital signs: see pointclickcare (computer program) -new orders: no new orders -progress to discharge plan: ongoing -additional information: non-weight bearing on left lower extremity until care provider says it okay to bear weight. During observation and interview on 7/24/23 at 12:36 p.m., R205 was laying in bed and both feet were wrapped in ACE bandages. Her left foot had reddish brown drainage seeping through the bandage. R205 stated no one had changed her bandages since she was admitted on 7/21/23 and the nurse (unknown) told her the doctor said she needed to keep the bandage on until her next doctor's appointment (7/26/23). During observation on 7/25/23 at 1:04 p.m., R205 was sitting in her wheelchair with her feet elevated on the bed. Her left foot had reddish brown drainage seeping through the bandage. R205 again stated, her bandages had not been changed since she was admitted. During observation on 7/26/23 at 9:52 a.m., R205 was sitting in her wheelchair in her room. Her left foot had reddish brown drainage seeping through bandage. R205 pointed to her bed linens which had several reddish brown (baseball sized) circular areas at the foot of the bed which she stated was drainage from the bandage on her left foot. During an interview on 7/25/23 at 1:53 p.m., licensed practical nurse (LPN)-A stated she noticed the bandage on R205's left foot had	F 684		

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F 684	Continued From page 9 drainage on it but she hadn't changed the dressing because the doctor's orders said it shouldn't be changed until her next doctor's appointment (7/26/23). She further stated she had planned on asking the primary physician about it when she did her rounds today. R205's medical record lacked any evidence LPN-A had contacted the doctor regarding the soiled bandage. During an interview on 7/26/23 at 10:32 a.m., LPN-B verified R205 had reddish brown drainage seeping through the bandage on her left foot and stated she had doctor's appointment today to have the wound on her foot looked at. During an interview on 7/26/23 at 10:45 a.m., nursing assistant (NA)-A stated she had changed R205's bed sheets and verified there were several reddish brown stains at the foot of her bed. During an interview on 7/26/23 at 2:46 p.m., RN-C-stated she had worked the previous night (7/25/23) and had noticed some old drainage on R205's left bandage on her foot. She further stated she did not change the bandage because she was told by LPN-A that it's been that way since R205 was admitted and to leave the dressing in place until her appointment tomorrow. RN-C stated if the drainage had "been new, she probably would've called someone about it." During an interview on 7/25/23 at 1:50 p.m., the DON verified R205 had reddish brown drainage seeping through the bandage on her left foot and stated it should be changed. The DON further stated (after reading the doctor's order) if the nurse looked at the dressing and there was blood	F 684		

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F 684	Continued From page 10 soaking through it, they would be responsible for changing it and calling the doctor. If the nurse looked at it (bandage) and it looked fine (no drainage), then they should leave it in place until the appointment. A policy on following doctor's orders was requested but not received.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		9/21/23

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F 756	Continued From page 11 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents (R26) reviewed for monthly medication regimen reviews (MRR). Findings include: R26's admission Minimum Data Set (MDS) dated 6/27/23, identified intact cognition, extensive staff assistance needed for dressing, limited staff assistance for hygiene, and diagnoses of bloodstream infection, irregular heart rhythms, blood clots and heart failure. R26 received antibiotics seven out of seven days in the lookback period, and received IV medications while a resident. R26's Monthly Pharmacist MRR dated 6/22/23, identified an irregularity for the admission order of isosorbide dinitrate five milligrams (mg) three times daily scheduled at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The pharmacist recommendation identified the medication timing should be changed to 8:00 a.m., 12:00 p.m. and 5:00 p.m. to allow for an adequate nitrate free period. The MRR lacked a response from the facility.	F 756	756 – Immediate correction for resident identified: Implementation of pharmacy recommendation completed and order updated. Corrective action to address potential resident affected: All house audit for outstanding pharmacy recommendations and completion. Actions taken to reduce potential for reoccurrence: Saint Therese of Woodbury Drug Regimen policy and procedure was reviewed and updated. Education and clarification provided to clinical leadership for timely review and completion of pharmacy reviews and monitoring for timely physician responses. How will corrections be monitored: Monitoring for completion of the reports will be done weekly for 4 weeks, monthly for 3 months, and quarterly thereafter. Results of audit to be presented to Quality Assurance and Review. Monitoring will be done by Director of Nursing or designee.	

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F 756	Continued From page 12 R26's subsequent physician and nurse practitioner visit notes dated 6/26/23, 7/5/23, and 7/11/23, lacked a response to the above pharmacist recommendations. R26's Medication Administration Record (MAR) orders dated 7/1/23 through 7/26/23, identified the following: -isosorbide dinitrate 5 mg three times a day to prevent angina (chest pain from reduced blood flow) from 6/21/23 through 7/5/23, -isosorbide dinitrate 10 mg by mouth three times a day to prevent angina from 7/5/23 through 7/13/23, -isosorbide dinitrate 20 mg by mouth three times a day to prevent angina from 7/13/23 and ongoing -the above medications were scheduled 8:00 a.m., 2:00 p.m., and 8:00 p.m. and not with the pharmacist recommendation of 8:00 a.m., 12:00 p.m., and 5:00 p.m. During an observation and interview on 7/27/23 at 8:33 a.m., registered nurse (RN)-D administered R26's morning medications which included isosorbide dinitrate. RN-D confirmed the administration times were 8:00 a.m., 2:00 p.m., and 8:00 p.m., and not the pharmacist recommendation of 8:00 a.m., 12:00 p.m., and 5:00 p.m. During an interview on 7/27/23 at 9:10 a.m., the director of nursing (DON) stated R26's pharmacy recommendations from 6/22/23, were not addressed and should have been. During an interview on 7/27/23 at 9:51 a.m., the facility's consultant pharmacist (CP) stated when the MRR recommendations identified an	F 756		

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F 756	Continued From page 13 irregularity, they should be addressed within 30 days unless otherwise indicated. The CP stated R26's time change recommendations were not followed up on by the facility and should have been since it was over 30 days and related to a cardiac medication, and R26's providers had been in the facility to visit R26 three times. The facility policy titled Medication Regimen Review dated 4/1/22, identified if the CP identified an irregularity that required urgent action, the DON or designee would be notified verbally. The policy lacked a timeline to respond to routine pharmacist recommendations to MRR irregularities.	F 756		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		9/21/23

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F 883	Continued From page 14 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer influenza vaccine to 2 of 5 residents (R19, R25), reviewed for immunizations.	F 883	883- Immediate correction for resident identified: Resident will be offered influenza vaccine upon acquisition of current seasonal influenza vaccine. Corrective action to address potential	

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F 883	Continued From page 15 R19's face Sheet in the electronic health record (EHR), indicated R19 diagnoses included Alzheimer's disease, dementia, and chronic obstructive pulmonary disease. R19's immunization record in the EHR,indicated R19 received the influenza vaccine 11/1/2020, however the record lacked indication R19 received the influenza vaccine in 2022. R19's EHR lacked indication R19 was offered and/or refused the influenza vaccine. R25's face sheet in the EHR,indicated R25's diagnoses included respiratory syncytial virus pneumonia, unspecific atrial fibrillation, and generalized anxiety disorder. R25's immunization record in the EHR, indicated R25 received the influenza vaccine in 10/30/19, however the record lacked indication R25 received the influenza vaccine in 2022. During interview on 7/27/23 at 10:51 a.m., the director of nursing (DON) and infection preventionist (IP) stated the facility had provided influenza vaccine, syringes, education and tools needed to administer the vaccine to residents, however the nurses failed to administer influenza vaccine to R19 and R25. Facility Influenza Policy dated 4/1/22, indicated, It is the policy of this facility, in collaboration with the medical director, to have an immunization program against influenza disease in accordance with national standards of practice. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this	F 883	residents affected: Saint Therese of Woodbury to offer Influenza vaccinations routinely on an annual basis from October 1st through March 31st unless such immunization is medically contraindicated the individual has already been immunized during this time period or refuses to receive the vaccine. Actions take to reduce potential for reoccurrence: Residents admitted during influenza vaccination period will be offered vaccine at the time of admission and documentation completed for acceptance or declination by resident or representative. Education will be provided to licensed nurses regarding vaccination process and policy. How will corrections be monitored: All residents will be audited that vaccinations were offered and documentation of completion or declination. Auditing will occur on a weekly basis for 4 weeks; then monthly for 3 months and quarterly thereafter. Results of audit to be presented to Quality Assurance and Review. Monitoring will be done by Director of Nursing, Infection Preventionist or designee.	

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F 883	Continued From page 16 time period, or refuses to receive the vaccine.	F 883		

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	245632	A. BUILDING **01 - ST THERESE OF WOODURY** B. WING _____	**07/26/2023**

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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 07/26/2023. At the time of this survey, ST THERESE OF WOODBURY was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 08/29/2023

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

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

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(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	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.145.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM,	K 345	1. Description of Corrective Action taken or planned to correct. Pull station was relocated to the opposite wall to avoid obstruction. 2. Measures to avoid it occurring again This will be added to our monthly fire door inspection checklist.	8/18/23

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	245632	A. BUILDING **01 - ST THERESE OF WOODURY** B. WING _____	**07/26/2023**

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K 345	Continued From page 3 it was revealed by observation that the manual fire alarm pull-station located in the Rosewood Nurses Station was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. This will be added to our monthly fire door inspection checklist. 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 353	1. Description of Corrective Action taken	9/8/23

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K 353	Continued From page 4 facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(2). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler heads located in the Kitchen exhibited signs of oxidation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	or planned to correct Sprinkler head is getting cleaned to remove the oxidation from the metal. 2. Measures to avoid it occurring again Annual sprinkler test will inspect all heads for oxidation. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Annual sprinkler test will inspect all heads for oxidation. 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or desginee	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		8/18/23

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K 372	Continued From page 5 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that documentation provided indicated that smoke damper inspection and testing is past due. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	1. Description of Corrective Action taken or planned to correct Smoke Damper inspection completed on 8/18/23 2. Measures to avoid it occurring again Added to Preventative Maintenance schedule for every 3 years. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Added to Preventative Maintenance schedule for every 3 years. Fire Alarm Company added it to their calendar as well. 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Desginee	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		8/16/23

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K 374	Continued From page 6 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the smoke barrier doors located on the 2nd floor of the building, adjacent to the elevators, exhibited an air gap greater than 1/8" An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	1. Description of Corrective Action taken or planned to correct Twin Cities Hardware came out to community on 8/16/23 adding smoke seal and adjusted doors. 2. Measures to avoid it occurring again Added to our Monthly Fire Door checks 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Added to our Monthly Fire Door checks 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Desginee	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101	K 541		10/1/23

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K 541	Continued From page 7 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the laundry and bio-hazard chute systems per NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.2, 5.2.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the	K 541	1. Description of Corrective Action taken or planned to correct Working with IFS to install fusible link to properly release doors properly. 2. Measures to avoid it occurring again Adding check to monthly fire extinguisher checks to ensure compliance going forward. 3. Indicate how the facility plans to	

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K 541	Continued From page 8 bio-hazard chute, located on the 2nd floor of the facility, upon testing of the door assembly did not self-close and latch to seal the vertical shaft. 2. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation in the Basement level, that the discharge cute in bio-hazard chute room was absent the proper hardware that would facilitate the automatic closure and sealing of the vertical shaft in the event of a fire. 3. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation in the Basement level, that the discharge cute in laundry chute room was absent the proper hardware that would facilitate the automatic closure and sealing of the vertical shaft in the event of a fire. It was also observed that plastic bags were tied to the chute door assembly to keep it in an open position - in leu of proper safety hardware. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	monitor future performance to ensure solutions are sustained. Adding check to monthly fire extinguisher checks to ensure compliance going forward. 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Designee	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience	K 761		9/15/23

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K 761	Continued From page 9 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2, 6.1.4.3.1 This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that the fire door assembly, in the area of the chapel, which separates the skilled nursing facility from the assisted living facility, in the area of the chapel, did not self-close and latch upon testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761	1. Description of Corrective Action taken or planned to correct Contractor schedule to repair door closure on 9/15/23. 2. Measures to avoid it occurring again Added to the Monthly Fire Door Check list 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Added to the Monthly Fire Door Check list 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Designee 5. Proposed date of completion Vendor scheduled to complete on 9/15/23.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		9/1/23

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K 920	Continued From page 10 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that on 2nd Floor in Office 2015 an extension cord was in use.	K 920	1. Description of Corrective Action taken or planned to correct Removed all power tap that were daisy chained or had an electrical appliance plugged in. All appliances are directly plugged into the wall outlet. 2. Measures to avoid it occurring again Educate Staff on the proper use of power taps. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	

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K 920	Continued From page 11 2. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that on 2nd Floor in the Med Room an appliance was connected to an extension cord. 3. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation, that on 2nd Floor in Office 2018 that relocatable power taps were daisy-chained together in use. 4. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that on 1st Floor in the Care Center Marketing Office a relocatable power tap was connected to an extension cord which was connected to a relocatable power tap. 5. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that on 1st Floor in the Social Services Office an appliance was connected to a relocatable power tap. 6. On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation in the Basement in the Environmental Services Office an extension cord was connected to relocatable power tap. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	-Inspect all offices every six months to confirm compliance 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Designee 5. Proposed date of completion Completed on 8/15/23 for correcting power tap issues. Education to be completed by 9/1/23.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923		9/15/23

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K 923	Continued From page 12 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 11.6.5, 11.6.5.2, 11.6.5.3. This	K 923	1. Description of Corrective Action taken or planned to correct All oxygen will be stored in the basement O2 Room designated specifically for	

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K 923	Continued From page 13 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/26/2023 between 10:00 AM and 2:00 PM, it was revealed by observation that on 2nd Floor in the Med Gas (O2) Storage Rooms there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	storage. No oxygen will be stored on 2nd Floor. Empty and filled cylinders will be stored in the O2 room in a designated spot identifying empty and full. 2. Measures to avoid it occurring again Staff education on the proper storage for med gas can not be stored on 2nd floor. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Plant Operations will add this to their monthly fire extinguisher check to confirm compliance to this process. 4. Identify who is responsible for the corrective actions and monitoring of compliance Plant Operations Director or Designee	

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	31025	A. BUILDING: _____ B. WING _____	C 07/27/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/24/23 through 7/27/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued: 1426, 1530, 1840. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/27/2023

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued during the survey: H56323944C (MN00095287), H56323866C (MN00087602), H56323864C (MN00087644), H56323868C (MN00083622), H56323869C (MN00095125), H56323992C (MN00084673), H56323993C (MN00091738), H56323865C (MN00087801), H56323867C (MN00090198). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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. 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. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
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	21426		9/21/23

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21426	Continued From page 3 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 employees (NA-B, NA-C and HK-D), received the required two-step tuberculin skin test (TST), and it was given timely. Nursing assistant (NA)-B's employee file, identified hire date was 3/23/23 and a first step TST was administered on 3/23/23, however, a second step TST was given on 7/26/23, 4 months after the first step TST. NA-C's employee file, identified hire date was 5/15/23 and a first step TST was administered on 5/15/23, however the record lacked a second step TST. Housekeeper (HK)-D's employee file, identified hire date was 4/6/23 and a first step TST was	21426	Corrected	

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21426	Continued From page 4 administered on 4/26/23, however, a second TST was given on 7/26/23, 3 months after the first step TST. During interview 07/27/23 at 10:51 a.m., the director of nursing and infection preventionist stated the second step TST is administered 2-3 weeks after the first step TST. The facility Tuberculosis Infectious (TB) Control Plan, indicated residents and staff are tested for latent TB infection and screened for TB disease, if infected with TB. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents records to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		9/21/23

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21530	Continued From page 5 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21530	Corrected	

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21530	Continued From page 6 review, the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents (R26) reviewed for monthly medication regimen reviews (MRR). Findings include: R26's admission Minimum Data Set (MDS) dated 6/27/23, identified intact cognition, extensive staff assistance needed for dressing, limited staff assistance for hygiene, and diagnoses of bloodstream infection, irregular heart rhythms, blood clots and heart failure. R26 received antibiotics seven out of seven days in the lookback period, and received IV medications while a resident. R26's Monthly Pharmacist MRR dated 6/22/23, identified an irregularity for the admission order of isosorbide dinitrate five milligrams (mg) three times daily scheduled at 8:00 a.m., 2:00 p.m. and 8:00 p.m. The pharmacist recommendation identified the medication timing should be changed to 8:00 a.m., 12:00 p.m. and 5:00 p.m. to allow for an adequate nitrate free period. The MRR lacked a response from the facility. R26's subsequent physician and nurse practitioner visit notes dated 6/26/23, 7/5/23, and 7/11/23, lacked a response to the above pharmacist recommendations. R26's Medication Administration Record (MAR) orders dated 7/1/23 through 7/26/23, identified the following: -isosorbide dinitrate 5 mg three times a day to prevent angina (chest pain from reduced blood flow) from 6/21/23 through 7/5/23, -isosorbide dinitrate 10 mg by mouth three times a day to prevent angina from 7/5/23 through	21530		

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21530	Continued From page 7 7/13/23, -isosorbide dinitrate 20 mg by mouth three times a day to prevent angina from 7/13/23 and ongoing -the above medications were scheduled 8:00 a.m., 2:00 p.m., and 8:00 p.m. and not with the pharmacist recommendation of 8:00 a.m., 12:00 p.m., and 5:00 p.m. During an observation and interview on 7/27/23 at 8:33 a.m., registered nurse (RN)-D administered R26's morning medications which included isosorbide dinitrate. RN-D confirmed the administration times were 8:00 a.m., 2:00 p.m., and 8:00 p.m., and not the pharmacist recommendation of 8:00 a.m., 12:00 p.m., and 5:00 p.m. During an interview on 7/27/23 at 9:10 a.m., the director of nursing (DON) stated R26's pharmacy recommendations from 6/22/23, were not addressed and should have been. During an interview on 7/27/23 at 9:51 a.m., the facility's consultant pharmacist (CP) stated when the MRR recommendations identified an irregularity, they should be addressed within 30 days unless otherwise indicated. The CP stated R26's time change recommendations were not followed up on by the facility and should have been since it was over 30 days and related to a cardiac medication, and R26's providers had been in the facility to visit R26 three times. The facility policy titled Medication Regimen Review dated 4/1/22, identified if the CP identified an irregularity that required urgent action, the DON or designee would be notified verbally. The policy lacked a timeline to respond to routine pharmacist recommendations to MRR irregularities.	21530		

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21530	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented	21840	Corrected	9/21/23

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21840	Continued From page 9 in all areas of the medical record for 1 of 22 residents (R33) reviewed for advanced directives. Findings include: R33's five-day Minimum Data Set dated 6/28/23, indicated moderate cognitive impairment and required extensive assist for most activities of daily living (ADLs). R33's Medical Diagnosis form in the electronic health record (EHR), indicated the following diagnoses: unspecified fracture of left femur, unspecified fracture of unspecified metacarpal bone, fracture of orbital floor, type two diabetes mellitus, unspecified fracture of facial bones, anemia in chronic kidney disease, chronic kidney disease stage four, malignant neoplasm of unspecified site of left female breast, age related osteoporosis with current pathological fracture. R33's progress note dated 6/22/23, indicated R33 was alert. R33's progress note dated 7/1/23, indicated R33 was alert and oriented. R33's medication administration profile printed 7/24/23, next to heading, Advance Directive indicated R33 wanted full treatment. R33's Clinical Census form in the EHR, indicated R33 wanted full treatment under the heading, Code Status. R33's physician orders dated 6/26/23, indicated R33 wanted full treatment. R33's physician orders for life sustaining treatment (POLST) dated 6/26/23, indicated R33	21840		

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21840	Continued From page 10 did not want resuscitation attempted. During interview on 7/24/23 at 7:16 p.m., registered nurse (RN)-A stated she looked on the computer or in the paper chart to find a resident's code status. During interview on 7/24/23 at 7:22 p.m., R33 stated she did not want cardiopulmonary resuscitation (CPR). During interview on 7/24/23 at 7:25 p.m., RN-B stated she looked at the medication administration record or checked the POLST in order to determine a resident's code status and stated they would call the physician if the code status didn't match. During interview on 7/24/23 at 7:31 p.m., RN-A stated she would perform CPR if a resident's heart stopped and there was a discrepancy in the medical record. During interview on 7/24/23 at 7:45 p.m., RN-B stated she would perform CPR if there was a discrepancy with the code status in EHR and in the paper chart. During interview on 7/25/23 at 8:16 a.m., licensed practical nurse (LPN)-C stated she would look at the banner in the EHR to determine a resident's code status, and if she was not by the computer, LPN-C would look at the POLST in the paper chart. LPN-C further stated she would start CPR right away if she was not sure about a resident's code status. During interview on 7/25/23 at 9:02 a.m., the director of nursing (DON) stated the code status was found either in the paper chart or in the EHR	21840		

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21840	Continued From page 11 on the banner. DON verified the banner in the EHR indicated R33 wanted full treatment and stated full treatment meant they would perform CPR on R33. At 9:14 a.m., DON verified R33's POLST indicated she did not want CPR. DON further stated code status discrepancies in a resident's medical record was a big risk because they might perform CPR, and the resident may not want CPR, or vice versa. DON verified physician orders dated 6/26/23, indicated full code status, contrary to R33's POLST which indicated R33 did not want CPR. A policy, Communication of Code Status dated 4/1/22, indicated it was the policy of the facility to adhere to residents' rights to formulate advance directives. When an order is written pertaining to a resident's presence or absence of an advance directive, the directions would be clearly documented in designated sections of the medical record. Examples of directions to be documented include full code, do not resuscitate, do not intubate, do not hospitalize. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. There was a section in the policy to identify the designated sections of the medical record, however the designated sections were not identified in the policy. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review the facility policy related to advanced directives and provide education to all staff. The quality assurance designee could monitor records for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	21840		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 22, 2023

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

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On July 18, 2023, we notified you a remedy was imposed. On November 17, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 13, 2023 be discontinued as of November 13, 2023. (42 CFR 488.417 (b))

In our letter of July 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 13, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2023

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

Re: Reinspection Results
Event ID: X8KC12, SXEC12, and 4V7Q12

Dear Administrator:

On August 31, 2023, October 4, 2023, and November 17, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on July 10, 2023, July 27, 2023, and October 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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