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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VZU2

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 **11/22/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **258** (L18)
13.Total Certified Beds **258** (L17)

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

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
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 :
Kathleen Lucas, Unit Supervisor 11/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
12/06/2017
(L33)

Posted 12/26/2017 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 245518

On November 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 5, 2017. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of November 14, 2017. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective November 14, 2017 and therefore remedies outlined in our letter to the facility dated October 19, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the October 5, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245518

December 18, 2017

Ms. Brooke Peoples, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

Dear Ms. Peoples:

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

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

Effective November 14, 2017 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.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2017

Ms. Brooke Peoples, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

RE: Project Number S5518028

Dear Ms. Peoples:

On October 19, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 5, 2017. 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 November 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 20, 2017 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 October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 14, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective November 14, 2017 and therefore remedies outlined in our letter to you dated October 19, 2017, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the October 5, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VZU2

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 **10/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds 258 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* 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): life Safety Code Annual Waiver of K521, was forwarded to the CMS Region V Office. Approval of the waiver has been recommended.

17. SURVEYOR SIGNATURE Date :
Andrea Schmitz - HFE Nursing Evaluator II 11/03/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/06/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/06/2017 Co.
LSC AW K521 sent to ROCHI 12/06/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 19, 2017

Ms. Brooke Peoples, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

RE: Project Number S5518028

Dear Ms. Peoples:

On October 5, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 14, 2017, 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 November 14, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (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 January 5, 2018 (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 April 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	10/05/2017

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 On 10/05/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 interview and document review the facility failed to implement care planned interventions for weekly weight monitoring for 1 of 3 residents (R55) reviewed for nutrition.	F 282	R55 is being weighed weekly per care planned intervention. All residents with the care plan intervention of weekly weight monitoring	11/14/17

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

Electronically Signed | 10/27/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	10/05/2017

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 282	Continued From page 1 Findings include: R55's significant change Minimum Data Set (MDS), dated 8/31/17, indicated a severe cognitive deficit with diagnoses of Alzheimer's Dementia, diabetes mellitus, osteoporosis, and hypertension (high blood pressure). It further indicated R55 required supervision with eating after meals were set up. The MDS identified R55 received a therapeutic diet and weighed 111 lbs. (pounds) at the time of assessment. No weight loss was identified on the MDS. R55's current orders were reviewed. R55's diet order consisted of a regular diet with no concentrated sweets. The orders further noted R55 received a protein gelatin supplement at bedtime and was offered a snack twice a day. The orders further directed staff to complete "Weight weekly on bath days." R55's current care plan, last revised 9/13/17, identified a risk of weight loss and decline related Alzheimer's Dementia and associated disease progression. The care plan noted R55's weight could fluctuate with cognition, directing staff to provide prompts and encouragement with meals, and assist as needed. The care plan further directed to monitor R55's weight weekly. R55's current nursing assistant (NA) care guide, undated, noted R55 received baths on Wednesday evenings and needed supervision with eating. The care guide did not identify R55 on weekly weights. Review of R55's weights, from 2/17 to 10/17, identified the following:	F 282	will be weighed weekly. All licensed staff, NARs and RD/DTRs have been educated on the facility policy and procedure of obtaining weekly weights per care planned intervention. Monitoring to ensure compliance will be completed by the DON or designee. Weekly audits will be performed on all residents requiring weekly weights for one quarter. Results of the audits will be reviewed by the QAPI committee for further recommendations.	

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 _____	10/05/2017

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
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- On 2/6/17, R55 weighed 120.3 lbs.
- On 3/6/17, R55 weighed 120 lbs.
- On 4/3/17, R55 weighed 119.4 lbs.
- On 5/3/17, R55 weighed 118 lbs.
- On 6/7/17, R55 weighed 113.4 lbs.
- On 6/28/17, R55 weighed 111.8 lbs.
- On 7/5/17, R55 weighed 113.4 lbs.
- On 7/26/17, R55 weighed 111.8 lbs.
- On 8/2/17, R55 weighed 111 lbs.
- On 8/22/17, R55 weighed 111.4 lbs.
- On 9/6/17, R55 weighed 110.8 lbs.
- On 9/20/17, R55 weighed 107.2 lbs.
- On 10/4/17, R55 weighed 109.5 lbs.

R55's medical record lacked weekly weights.

During interview on 10/4/17, at 6:24 p.m. RN-C thought R55's weights were done weekly, reporting R55 had been loosing weight and needing more assistance. RN-C reported the dietician and nurse managers monitored weekly weights, and the dietician would update the nurse manager if weights were not being completed.

During interview on 10/5/17, at 10:33 a.m. nursing assistant (NA)-C stated most residents, including R55, were weighed monthly with their first bath of the month. NA-C stated some were weekly if the nurse practitioner (NP) ordered it. NA-C looked at her "care guide," which did not list R55 as a weekly weight.

During interview on 10/5/17, at 12:07 p.m. RN-B stated she was was not aware R55's weights were not being completed weekly, she further stated weights were typically done monthly, but R55's were actually ordered weekly. RN-B reported the dietician usually monitored the weights and updated her if weights were missing. RN-B reported the weekly weights were being

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F 282	Continued From page 3 checked off as "completed" on R55's treatment record (TAR), but no actual weight was being taken or recorded. RN-B stated she "will need to fix that." During interview on 10/5/17, at 12:24 p.m. the dietician reviewed R55's weights and acknowledged "she is dropping." The dietician stated she was not aware that R55's weights were not completed weekly. The dietician reported R55 had had a 7.5% weight loss at the time of the nutritional assessment in August, and although R55's body mass index (measure of a persons body fat, based on weight and height) remained normal, the loss might have been caught sooner if the weights had been taken weekly During interview on 10/5/17, at 3:22 p.m. the director of nursing (DON) stated they were aware of the nutrition concern, and were in the process of hiring another dietician. The DON stated they were also re-doing their process so the dieticians reported nutrition concerns to nursing instead of dietary.	F 282		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable	F 325		11/14/17

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F 325	Continued From page 4 body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to recognize, assess, and monitor weight loss for 1 of 3 residents (R55) reviewed for nutrition. Findings include: R55's significant change Minimum Data Set (MDS), dated 8/31/17, indicated a severe cognitive deficit with diagnoses of Alzheimer's Dementia, diabetes mellitus, osteoporosis, and hypertension (high blood pressure). It further indicated R55 required supervision with eating after meals were set up. The MDS identified R55 received a therapeutic diet and weighed 111 lbs. (pounds) at the time of assessment. No weight loss was identified on the MDS. R55's current orders were reviewed. R55's diet order consisted of a regular diet with no concentrated sweets. The orders further noted R55 received a protein gelatin supplement at bedtime and was offered a snack twice a day. The orders further directed staff to complete "Weight weekly on bath days." R55's current care plan, last revised 9/13/17, identified a risk of weight loss and decline related Alzheimer's Dementia and associated disease	F 325	R55 has been assessed and is being monitored for weight loss. All residents will be monitored and assessed for weight loss. All licensed staff and NARs have been educated on the process for obtaining and documenting daily, weekly and monthly weights. The RDs/DTR have been educated on the policy and procedure for assessing and monitoring weights to ensure all residents maintain nutritional status. Monitoring to ensure compliance will be completed by the DON or designee. Weekly audits will be performed on all residents for one quarter. Results of the audits will be reviewed by the QAPI committee for further recommendations.	

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progression. The care plan noted R55's weight could fluctuate with cognition, directing staff to provide prompts and encouragement with meals, and assist as needed. The care plan further directed to monitor R55's weight weekly.

Review of R55's weights, from 2/17 to 10/17, identified the following:
- On 2/6/17, R55 weighed 120.3 lbs.
- On 3/6/17, R55 weighed 120 lbs.
- On 4/3/17, R55 weighed 119.4 lbs.
- On 5/3/17, R55 weighed 118 lbs.
- On 6/7/17, R55 weighed 113.4 lbs.
- On 6/28/17, R55 weighed 111.8 lbs.
- On 7/5/17, R55 weighed 113.4 lbs.
- On 7/26/17, R55 weighed 111.8 lbs.
- On 8/2/17, R55 weighed 111 lbs.
- On 8/22/17, R55 weighed 111.4 lbs.
- On 9/6/17, R55 weighed 110.8 lbs.
- On 9/20/17, R55 weighed 107.2 lbs.
- On 10/4/17, R55 weighed 109.5 lbs.

The record indicated R55's weight had declined since March. R55's medical record lacked weekly weights.

A nutritional progress note dated, 6/12/17, identified the dietician had changed R55's nutritional supplements, discontinuing snacks three time a day, and added the protein gelatin supplement to help with blood sugar management. The note directed to follow up with concerns and changes as needed. The note did not address R55's weight loss.

R55's most recent Nutritional Assessment, dated 9/12/17, noted her meal intake was poor 50% of the time, noted she was on a supplement, and had a normal BMI (body mass index-the measure of a persons body fat based on weight and

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height). It further identified her admission weight was 124.4 lbs, with her current weight of 110.8 lbs. However, the assessment lacked identification of a weight loss, marking "no" to weight changes and lacked monitoring of weekly weights.

R55's medical record lacked assessment of the weight loss despite intake of a supplement and nutritional snacks.

During observation on 10/4/17, at 12:00 p.m. R55 was observed at lunch. R55 was able to eat independently after set up, eating approximately half of her main entree, until 1:00 p.m., when she began to pick at the food, using the fork to push it around on her plate. R55 did not touch her salad or dessert.

During observation on 10/4/17, at 5:07 p.m. R55 was observed at supper. R55 was able to eat independently after set up, using her spoon to scoop up sloppy joe hamburger and tator tots, and picking the bun apart with her hands. At 5:42 p.m., registered nurse (RN)- approached R55 and asked if she would like jello. R55 agreed and RN- administered R55's protein gelatin supplement. R55 had eaten approximately 75% of her meal.

During interview on 10/4/17, at 6:24 p.m. RN-C stated R55's ability to eat varied day to day, reporting some days she needed reminders or actual assistance. RN-C acknowledged R55 was on a gelatin protein supplement for her blood sugars, and had eaten about 50% of the supplement that evening. RN-C stated the gelatin was the only supplement R55 received. RN-C thought R55's weights were done weekly,

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reporting R55 had been loosing weight and needing more assistance. RN-C reported the dietician and nurse managers monitored weekly weights, and the dietician would update the nurse manager if weights were not being completed.

During interview on 10/5/17, at 10:33 a.m. nursing assistant (NA)-C stated most residents, including R55, were weighed monthly with their first bath of the month. NA-C stated some were weekly if the nurse practitioner (NP) ordered it. NA-C looked at her "care guide," which did not list R55 as a weekly weight. NA-C reported R55 was a "very good" eater, and needed set up assistance and reminders to eat.

During interview on 10/5/17, at 12:07 p.m. RN-B stated she was was not aware R55's weights were not being completed weekly, further stating weights were typically done monthly, but R55's were actually ordered weekly. RN-B reported the dietician usually monitored the weights and updated her if weights were missing. RN-B reported the weekly weights were being checked off as "completed" on R55's treatment record (TAR), but no actual weight was being taken or recorded. RN-B stated she "will need to fix that."

During interview on 10/5/17, at 12:24 p.m. the dietician reviewed R55's weights and acknowledged "she is dropping." The dietician reported R55 had been moved to the locked memory unit in April, and "is just not doing so hot." She further stated " I didn't realize" R55 had had a weight loss, reporting she ran monthly weight reports and was not aware R55's weights were not completed weekly. The dietician reported R55 had had a 7.5% weight loss at the time of the nutritional assessment in August and,

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F 325	Continued From page 8 although R55's BMI remained normal, the loss might have been caught sooner if the weights had been taken weekly. The dietician reported she had decreased the frequency of snacks and added a gelatin protein supplement to stabilize R55's blood sugars. However, she had not been aware of the weight loss, and although R55 had not met the percent loss for significant change in August, should have written a note addressing the weights were trending downward. During interview on 10/5/17, at 3:22 p.m. the director of nursing (DON) stated they were aware of the nutrition concern, and were in the process of hiring another dietician. The DON stated they were also re-doing their process so the dieticians reported nutrition concerns to nursing instead of dietary. A facility policy entitled Nutritional Assessment, revised 9/11, directed a nutritional assessment would be completed by the dietician, nursing staff, and healthcare providers upon admission, and "as indicated by a change in condition that places the resident at risk for impaired nutrition."	F 325		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (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;	F 334		11/14/17

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(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 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.

(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

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F 334	Continued From page 10 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 ensure the Pneumococcal Conjugate Vaccine-13 (PCV13) as recommended by the Centers for Disease Control (CDC) were offered to 3 of 5 residents (R64, R346, R279) whose vaccination histories were reviewed. Findings include: The CDC identified the Advisory Committee on Immunization Practices (ACIP) recommends that all adults 65 years of age or older receive a dose of PCV13 followed by a dose of PPSV23 at least one year later. In addition, if an adult has previously received a dose of PPSV23, wait one one year and receive a dose of PCV13. R64's Immunization Record, dated 10/4/17, indicated R64 had received Pneumovax immunization on 1/01/03. However, the medical record lacked evidence R64 received or was offered the PCV13 vaccination as recommended	F 334	R64, R346, R279 have all been offered the PCV13 vaccine. All residents will be offered the PCV13 vaccine as recommended by the CDC. All licensed staff have been educated on the pnuemovac policy implementation. Monitoring to ensure compliance will be completed by the DON or designee. Weekly audits will be performed on new admissions to ensure pneumovacs are completed per policy. Results of the audits will be reviewed by the QAPI Committee for further recommendations.	

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by the CDC. Based on age, R64 met the criteria to receive the PCV13 vaccination.

R346's Immunization Record, dated 10/4/17, indicated R34 had received the Pneumovax immunization on 4/20/04. The medical record lacked evidence R346 received or was offered the PCV13 vaccination as recommended by the CDC. Based on age, R346 met the criteria to receive the PCV13 vaccination.

R279's Immunization Record, dated 10/4/17, indicated R279 had not received the PCV13 or the PPSV23 vaccination. The medical record lacked evidence R279 was offered the PCV13 vaccination as recommended by the CDC. Based on age, R279 met the criteria to receive the PCV13.

During interview on 10/04/17, at 6:45 p.m. assistant director of nursing (ADON), who was responsible for the facility's infection control program, acknowledged the facility was aware of the CDC recommendations related to pneumococcal vaccines. She verified R64 and R346 had not received the PCV13 vaccine, and R279 had not received any pneumococcal vaccines. The ADON reported the facility was aware of the pneumococcal vaccination guidelines, and they had begun a tracking system to ensure CDC recommendations were being followed. However, the facility had not completed the new system yet.

During interview on 10/5/17, at 10:03 a.m. the director of nursing (DON) indicated she was aware the CDC recommendations related to pneumococcal vaccines had not been implemented for R64, R346 and R279. The DON

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F 334	Continued From page 12 indicated the facility was in the process of improving their system as part of an infection control improvement plan. During interview on 10/5/17, at 2:56 p.m. the administrator stated the facility's quality assurance performance improvement (QAPI) committee had just started looking at and auditing for the PCV13 vaccinations, and knew the vaccinations were a concern. The facility policy entitled Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults, Including Geriatric Residents Policy,undated, directed all residents would be assessed and screened for need of vaccination and provided appropriate pneumococcal PCV13 and PPSV23 vaccines unless contraindicated. The policy also indicated the facility would document the administration of the vaccine and the publication date of Vaccine Information Statement provided. If vaccine was not administered, the record would indicate reason for non-receipt of the vaccine.	F 334		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 431		11/14/17

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dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

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F 431	Continued From page 14 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications stored in unit refrigerators were secured when unattended on 1 of 4 units observed for medication storage. This had the potential to affect 27 residents residing on this unit. Findings include: During the initial facility tour on 10/2/17, at 7:27 a.m. two red plastic boxes were observed in the second floor east pantry refrigerator. Both boxes were attached to one end of an approximately three foot metal chain. The other end of the chain was not attached to the refrigerator, therefore, could be removed. One of the red boxes was not locked, and contained the following medications: a bottle of glatopa injection (medication used to treat multiple sclerosis), a bottle of Tubersol solution (medication used to test for tuberculosis), and Novolin insulin pens. The other red box was secured with a padlocked and contained plastic bags with intravenous antibiotics: vancomycin and Rocephin. During an interview on 10/2/17, at 7:27 a.m. registered nurse (RN)-A stated the locked boxes were usually locked and chained together. RN-A stated the refrigerator door was not locked, and food items for residents were stored in the refrigerator with the medication. RN-A stated the one red box that was padlocked contained "just antibiotics. RN-A was observed to remove the padlock from one box to place the padlock on the the other box, leaving the box with the antibiotic medication unsecured.	F 431	Medications stored in the unit refrigerator have been secured. All medications stored in all unit refrigerators have been secured. All licensed staff have been educated on proper medication storage for refrigerated medications. Monitoring to ensure compliance will be completed by the DON or designee. Weekly audits will be performed for 3 months on all refrigerators designated for medication storage to ensure proper secured locking mechanisms are in place. Results of the audits will be reviewed by the QAPI Committee for further recommendations.	

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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 431	Continued From page 15 During interview on 10/02/17, at 7:28 a.m. clinical manager (CM)-C stated he had identified the concern with storing red locked medication boxes in the refrigerators approximately three weeks prior. CM-C stated he had informed the administrator of the concern. CM-C stated he had requested a smaller fridge be ordered in order to move the refrigerated medications to a locked area. CM-C reported he was not aware if refrigerators had been ordered. During interview on 10/5/17, at 2:56 p.m. the administrator stated she had learned a month prior that the facility did not have actual medication storage rooms. The administrator further stated she was aware of medications being stored in red boxes in the pantry refrigerators. The administrator stated she became aware of the issue about a week ago from CM-C, who had asked to order separate refrigerators; however, she had not followed up on the concern. The administrator reported she had not observed the red boxes until that day. The administrator stated storing medications like that was, "not okay." She further stated she had ordered several smaller refrigerators that day. An order receipt from Amazon.com, dated 10/5/17, indicated" three single door refrigerators" were ordered on 10/5/17. A facility policy on refrigerated medication storage was requested; however, the facility indicated there was no policy.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		11/14/17

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F 441	Continued From page 16 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 441		

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F 441	Continued From page 17 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate signage for contact precautions to minimize the spread of infection for 2 of 2 residents (R441, R443) reviewed for infection control. This had the potential to affect all 51 residents who resided on the second floor of the facility and their visitors. In addition, the facility failed to report an influenza outbreak to the appropriate state agency (SA). Findings include: ISOLATION SIGNAGE	F 441	R441□s infection has since resolved. Proper signage has been placed outside of R443□s room. All residents with infections requiring precautions have had proper signage placed out of their room to prevent the spread of infection to staff, other residents and visitors. All licensed staff have been educated on the facility infection control policy and procedure, which includes placement of appropriate signage for residents on precautions.	

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F 441	Continued From page 18 During observation on 10/3/17, at 8:13 a.m. R441's room door was observed open, and had a white cart with three yellow drawers outside his room. There was no signage attached to the door, directing visitors to report to the nurses station before entering the room, or information regarding contact precautions. During interview on 10/3/17, at 8:16 a.m. nursing assistant (NA)-A indicated the cart outside R441's room was for infection protection, and she put on a gown and gloves before entering the room. She indicated she would ask the nurse if she had any questions. During observation on 10/3/17, at 4:19 p.m. R441's door was open, and he was lying in bed. A female visitor was observed in R441's room sitting near the door in a wooden folding chair. The visitor was approximately 5 feet from R441's bed, and was not wearing personal protective equipment (PPE). There was no signage on the door instructing the visitor to report to the nurses' station before entering the room. During observation on 10/4/17, at 11:40 a.m. a a white cart with three yellow drawers was located across the hall from R443's room. There was no signage attached to the door, directing visitors to report to the nurses station before entering the room, or information regarding contact precautions. During interview on 10/04/17, at 11:57 a.m. registered nurse (RN)-A indicated R441 was on contact precautions due to C-Diff (clostridium difficile, drug resistant bacteria) infection. RN-A indicated the facility was supposed to have a precaution note on the door to alert visitors to	F 441	All personnel involved in the infection control program oversight have been educated on the requirement of reporting outbreaks per MDH and/or CDC guidelines. Weekly review of the infection control line lists will be completed as part of the IDT meeting. Monitoring to ensure compliance will be completed by the DON or designee. Weekly audits will be performed for 3 months on all residents requiring precautions to ensure proper signage has been placed outside of the room. Monthly audits of the infection control log will be completed to ensure the appropriate reporting of outbreaks is completed. Results of the audits will be reviewed by the QAPI Committee for further recommendations.	

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F 441	Continued From page 19	F 441		

report to the nurse before entering the room. RN-A indicated the facility had a report every morning, and at that time the nursing staff were told who was on contact precautions.

During interview on 10/04/17, at 12:07 p.m. the assistant director of nursing (ADON), who was responsible for the facility's infection control program, confirmed signage should be used on resident doors to notify staff and visitors of contact precautions.

During interview on 10/5/17, at 7:49 a.m. nurse manager (NM)-A verified there had not been signage on R441's door to notify staff and visitors to report to the nurses station before entering the room. NM-A indicted R441 was admitted on 9/11/17, with a C-Diff infection and was currently on contact precautions.

During interview on 10/5/17, at 8:08 a.m. NM-B indicated R443 was placed on contact precautions for a C-Diff infection on 9/18/17. She verified R443 was still on contact precautions. NM-B indicated she was not aware that R443 did not have a sign on her door with instructions for visitors to report to the nurses station before entering the room. She stated a sign should be in place on the door.

During interview on 10/5/17, at 10:00 a.m. the director of nursing (DON) verified she was aware of the lack of signage on R441 and R443's doors while they were on contact precautions, with instruction for visitors to report to the nurses station before entering the room. The DON stated her expectation was that, according to the facility policy, signs should have been on the doors of R441 and R443 while they were on contact

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precautions.

The facility policy entitled Isolation-Categories of Transmission-Based Precautions, revised January 2012, instructed the facility to utilize a sign and system to identify contact precautions for staff and visitors.

The facility policy entitled Clostridium Difficile, revised July 2014, indicated visitors would be encouraged to wear gowns and gloves, and be instructed on proper hand hygiene.

OUTBREAK REPORTING
The facility's illness tracking form entitled Influenza-Like Illness (ILI) Line List, dated 2/17, identified seventeen confirmed cases of influenza and/or influenza illness. The facility's infection control program lacked documentation that the outbreak was reported to the appropriate state agency (SA).

During interview on 10/4/17, at 6:45 p.m. the ADON verified seventeen confirmed cases of influenza and/or influenza like illnesses were listed on the facility's February 2017 ILI, Line list tracking form. She indicated she was aware the facility was required to report influenza outbreaks to the state agency but was not aware if the facility had reported the outbreak in February.

During interview on 10/5/17, at 7:44 a.m. the ADON confirmed the facility had not reported any influenza outbreaks that occurred in the facility as indicated on the February 2017 ILI, Line list tracking form.

During interview on 10/5/17, at 10:03 a.m. the DON indicated the facility should have reported

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F 441	Continued From page 21 the influenza outbreak in the facility. The facility's policy entitled Infection Prevention and Control Program, revised August 2016, instructed the facility, for outbreak management, to report the information to appropriate public health authorities. The facility's policy entitled Infection Prevention, (IP): Surveillance and Outbreak Plan dated September 2013, included the page titled Diseases Reportable to the Minnesota Department of Health. This form instructed staff to report Influenza; unusual case incidents, critical illness or laboratory confirmed cases within one working day.	F 441		
F 469 SS=F	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate pest control was maintained to control an infestation of mice throughout the facility. This had the potential to affect all 234 residents residing in the facility and their visitors. Findings include: Review of an email dated 9/29/17, at 12:13 p.m. from the regional ombudsman assigned to the facility, included, "mice have been a major concern." The email further identified the ombudsman had continued to receive reports by various family members of seeing mice in public	F 469	R320, R447, and R63□s rooms have all been assessed for pest control issues. All pest sightings will be reported to maintenance personnel and logged in the pest sighting log book. Rooms with pest sightings will be assessed per protocol established with the facility pest control vendor. All staff have been educated on the requirement of reporting pest sightings to maintenance personnel and the pest control policy and procedure. Maintenance personnel have been educated on the pest control policy and procedure and the pest sighting protocol	11/14/17

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F 469	Continued From page 22 areas and rooms, for many months, despite exterminator involvement. During interview on 10/2/17, at 9:53 a.m. R320 stated, "I had mice in bed with me about 3-4 weeks ago. It got up on my feet." R320 pointed to a trap in his room on the facility's 1st floor and stated facility staff and an "outside guy" who had told him the whole building was infested with mice. R320 stated he had seen mice a total of four times and added, "That's not pleasant. This is my home and they need to treat it that way." During observation on 10/2/17, at 10:28 a.m. a surveyor saw a mouse run in the hallway on the facility's first floor, and into room 132. During interview on 10/3/17, at 3:29 p.m. R447 and his visitor stated they had seen mice running in and out of his room, which was located on the facility's 2nd floor, several times since his admission to the facility and as recently as last week. R447 stated the mice would come in the door and run behind a dresser in the room. Upon observation, mouse droppings and a mouse trap were noted inside the bottom drawer of the dresser, a mouse trap was behind the recliner, and two bait traps were placed along the perimeter of the room. During interview on 10/4/17, at 3:31 p.m. family member (F)-A stated, "I know they have a mice problem. There is mouse traps all over the place." F-A stated the problem had been ongoing since his family member was admitted in October, 2015. F-A added, "They tell me they are trying to get it under under control." During interview on 10/5/17, at 8:55 a.m. the	F 469	established with the facility pest vendor. Monitoring to ensure compliance with be completed by the Director of Plant Operations or designee. Weekly audits will be performed on resident rooms, the pest sighting log book, and the facility pest vendor visit reports to ensure compliance with the facility pest control policy and procedure.	

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director of plant operations (DPO) stated the facility had a working relationship with an exterminating company, which visited the facility twice a month per contract. The DPO stated, as soon as a mouse sighting was reported, the maintenance staff assessed the area by checking for food sources, checking for openings, and working to close those openings. The DPO stated bait stations were put in those areas and the activity in those areas was monitored. The DPO stated facility staff alerted maintenance of mouse sightings with work orders, phone calls, and emails. The sightings were also logged to help the exterminating service do their job. The DPO stated outdoor audits were done and traps were set up all around the perimeter. The DPO stated, "One mouse in the facility is too many."

During interview on 10/5/17, at 9:01 a.m. R63 stated she had seen mice several times in the facility, and saw a mouse a couple of days ago that ran across the hallway on the facility's third floor.

During observation on 10/5/17, at 11:24 a.m. a second surveyor saw a mouse run from room 132 into room 133 on the facility's first floor.

During interview on 10/5/17, at 11:24 a.m. registered nurse (RN)-B stated she had been calling maintenance "weekly" with sightings of mice and had told staff to report sightings as well. RN-B further stated maintenance staff had responded by putting more traps in the vents. RN-B stated, regarding the mice sightings, "That is so gross."

During a telephone interview on 10/6/17, at 11:20 a.m. the Orkin branch manager (OBM) stated a

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technician visits this facility every two weeks and works with the facility to address the mice issue by assessing and refilling bait stations and giving recommendations to stop the point of entry for the mice. The OBM stated he visited the facility with the technician in the spring of this year, and they walked around the perimeter of the facility and inside the facility with facility staff. The OBM stated at that time they discussed "points of entry" where mice can get in. The OBM stated he and the technician pointed out areas that could be sealed up better with caulking and sealing, discussed cleaning up the dumpster area, pointed out receiving doors that were left open, and put bait stations all around the facility. The OBM stated there was "all sorts" of open food in rooms and around the facility, and they discussed that food needs to be stored in sealed containers to deter mice. The OBM stated, "It's always a collaboration effort with the facility. There are multiple things on their part that could be done. They could clean up the dumpster areas and fix the points of entry. Some doors are old and rusty. They need to be replaced, and they need door sweeps." The OBM stated the technician has made recommendations to the facility's maintenance staff with each visit. The OBM stated visiting the facility more often "wouldn't probably do any good," because, "The real problem is the point of entry."

Review of the facility's Pest Activity Log, from 1/17 through current date, 33 mouse sightings were documented with locations throughout the facility, with 30 of the sightings noted since 7/10/17.

Review of the facility policy entitled Pest Control Program, initiated (2/26 no year) included, the

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F 469	Continued From page 25 facility utilizes an Integrated Pest Management (IPM) program to alleviate pest and rodent problems with the least possible hazard to people, property, and the environment. The policy further included, "Management understands that removing the essential survival needs of pest and rodents-food, water, and shelter-or blocking access to these needs is essential to an effective Pest Management Program. Therefore, our IPM program is focused on addressing why pest are present in the first place instead of merely trapping or killing them."	F 469		

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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, Fire Marshal Division on October 03, 2017. At the time of this survey, St. Therese Home 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) 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us, and Angela.Kappenman@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. The building is fully fire sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 258 beds and had a census of 231 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing 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 STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility did not maintain the sprinkler system in accordance with NFPA 25 and LSC (12) edition section 9.7.5, 9.7.7, 9.7.8. This deficiency could affect all 231 residents in the event of a malfunction. Findings include:	K 353	The dry sprinklers in the coolers have been changed. The 5 year sprinkler test has been completed. The sprinkler system gauges have been recalibrated or replaced. All dry sprinklers over 10 years old will be changed. The 5 years sprinkler test will be completed timely, every 5 years. All sprinkler system gauges over 5 years old	11/14/17

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 _____	**10/03/2017**

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 353	Continued From page 3 On facility tour between the hours 12:00 PM and 4:30 PM on 10/03/2017, it was revealed during documentation review of the annual sprinkler company report that there were (3) items that need to be addressed. These items are: 1. The dry sprinklers in the coolers are over 10 years old and need to be changed. 2. The 5 year sprinkler obstruction test is due. 3. The sprinkler system gauges are over 5 years and need to be recalibrated or replaced. This deficient practice was verified by the Maintenance Supervisor at the time of inspection.	K 353	will be recalibrated or replaced. Maintenance staff have been educated on the requirements of the sprinkler system. Monitoring to ensure compliance will be completed by the Director of Plant Operations. Audits will be completed to ensure work was completed. These items will be added to the preventative maintenance task list according to the required timeframe.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC (12), Section 19.5.2.1. A noncompliant HVAC system could affect all 231 residents. Findings include: During the facility tour between 12:00 PM and	K 521	A continuing waiver is being requested for K521. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: The cost estimate for complying HVAC system dated 4/8/2014 is $1,000,000. Financing costs at 5% add an additional $272,768 to the project. Under current reimbursement rates, we estimate that it	11/14/17

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 _____	**10/03/2017**

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ST THERESE HOME	**8000 BASS LAKE ROAD** **NEW HOPE, MN 55428**

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K 521	Continued From page 4 4:30 PM on 10/03/2017, observations and an interview with Maintenance Director revealed that the ventilation system on the 1st, and 2nd floors in the 1968 construction utilizes the egress corridor as the return air for the resident rooms. This finding was verified with the Maintenance Supervisor at the time of discovery. Date of building construction is 1968.	K 521	takes 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 effect their quality of life with the construction noise, dust, and obstructions. The building design with a fixed, solid corridor ceiling limits installation options because of inadequate headroom that would result in adding ductwork. The current ceiling height is 8 feet, the addition of ducts and ceiling materials would reduce the headroom to less than 6□5. The building is currently 49 years old and strategic planning for the organization has begun for the future of this building. There will be no adverse effect on the building occupants safety in accordance with SOM2480B, because St. Therese Home is a 3 level, Type II building structure with interior finish ratings for flame 20 and smoke 85 on the first floor, flame 25 and smoke 45 on the 2nd floor, and flame 15 and smoke 30 on the 3rd floor. The walls, floors, ceilings and vertical openings were designed and constructed to resist the passage of smoke. There are three smoke compartments on each floor of the facility. Trainin for staff on the facility compliant fire safety plan is conducted annually. The facility is fully sprinkled. A fire watch procedure is implemented whenever the fire alarm more fire sprinkler system is down for maintenance, repair, or upgrades. The Plant Operations Supervisor has been designated and trained for conducting the Fire Watch	

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/03/2017**

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K 521	Continued From page 5	K 521	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 3 minute response time. The fire alarm systems (pull stations, smoke/heat detection, and 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 MN Fire Marshall office. The facility staffing ratio is 1 staff per 1.3 residents in a 24 hour period.	

Name of Facility

St. Therese Home

2012 LIFE SAFETY CODE

PART III – 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
K400 K521 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	A) A continuing waiver is being requested for K521. 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 currently 48 years old and is slated for replacement in 2018. 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)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 12-01-17

Name of Facility St. Therese Home **2012 LIFE SAFETY CODE**

PART III – 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
K400 K521 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	(B continue) • 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 is fully sprinkled. • 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)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 12-01-2017