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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZLT2

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 **02/01/2017** (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):
Facility's request for a continuing waiver involving K351 is recommended

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 02/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/17/2017 (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
01/26/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245518
February 17, 2017

Ms. Dinah Martin, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

Dear Ms. Martin:

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

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

Effective January 10, 2017 the above facility is certified for or recommended for:

258 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 258 skilled nursing facility beds located in rooms .

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521. You will receive notification from CMS only if they do not concur with our recommendation.

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(ies) 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.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 17, 2017

Ms. Dinah Martin, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

RE: Project Number S5629001

Dear Ms. Martin:

On December 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 10, 2017 and therefore remedies outlined in our letter to you dated December 15, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the December 1, 2016 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.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245518 Y1	A. Building B. Wing Y2	2/1/2017 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0272	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	01/10/2017	LSC	01/10/2017	LSC	01/10/2017
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	01/10/2017	LSC	01/10/2017	LSC	01/10/2017
ID Prefix F0356	Correction	ID Prefix F0371	Correction	ID Prefix F0441	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed
LSC	01/10/2017	LSC	01/10/2017	LSC	01/10/2017
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/10/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 02/17/2017	SIGNATURE OF SURVEYOR 37040	DATE 02/01/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 17, 2017

Ms. Dinah Martin, Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN 55428

Re: Reinspection Results - Project Number S5518027

Dear Ms. Martin:

On February 1, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00261 Y1	A. Building B. Wing Y2	2/1/2017 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20540	Correction	ID Prefix	20565	Correction	ID Prefix	20830	Correction
Reg. #	MN Rule 4658.0400 Subp. 1 & 2	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	20900	Correction	ID Prefix	20920	Correction	ID Prefix	21385	Correction
Reg. #	MN Rule 4658.0525 Subp. 3	Completed	Reg. #	MN Rule 4658.0525 Subp. 6 B	Completed	Reg. #	MN Rule 4658.0800 Subp. 3	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		12/01/2016
ID Prefix	21665	Correction	ID Prefix	21805	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.1400	Completed	Reg. #	MN St. Statute 144.651 Subd. 5	Completed	Reg. #		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 02/17/2017	SIGNATURE OF SURVEYOR 37040	DATE 02/01/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZLT2

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 **12/01/2016** (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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):
Facility's request for a continuing waiver involving K521 is recommended

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 12/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/23/2017 (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
AW K521 Emailed to ROCHI 01/31/2017 Co.
.
Posted 01/26/2017 Co.
.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 15, 2016

Ms. Dinah Martin, Administrator
St. Therese Home
8000 Bass Lake Road
New Hope, MN 55428

RE: Project Number S5518027

Dear Ms. Martin:

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 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 January 10, 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 March 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as

mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5518070 was completed and found not to be substantiated. 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal grooming to promote dignity for 1 of 3 residents (R202) reviewed for activities of daily living and grooming. Findings include: R202's quarterly Minimum Data Set (MDS) dated	F 241	Persons responsible: Clinical Coordinators, DON, and/or designee It is the policy of St. Therese to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. "The Resident Care: Grooming" policy and the	1/10/17

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

Electronically Signed | 12/23/2016

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F 241	Continued From page 1 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in the lounge area sitting with her daughter. R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her	F 241	NA/R Care Audit were reviewed and updated by ADON of Indirect Care. The audit was updated to specifically add facial hair grooming. To assure continued compliance, the following plan has been implemented: 1. R202 was appropriately groomed on 12/1/16 on the PM shift. Utilize the NA/R Care Audit to assess cares for R202 once on the AM shift and once on the PM shift on 12/23/16. Per the results of the Care Audit, education on appropriate resident grooming will be provided as needed. 2. Use NA/R Care Audit for random audits to ensure that grooming, specifically facial hair and nail care, is being completed. Beginning 12/23/16, there will be 6 audits per unit per week performed for the duration of one month. Any corrective action will be immediately addressed with staff while at the POC, or in private with the staff member, if necessary, until compliance is achieved as determined by the QI/QA committee and their recommendations. 3. Reeducating nursing staff involved in direct patient care on "Resident Care: Grooming" policy beginning on 12/23/16. Licensed staff will continue to complete a weekly skin assessment on each resident's bath day which will include assessing nail care, facial hair, and overall grooming. Re-education upon completion of skin assessment started on 12/22/16.	

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F 241	Continued From page 2 mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this." During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands. During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing. During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed. During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B she verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.	F 241	4. The results of the random NA/R Care Audits will be reported to the QI/QA committee. Revisions made per QI/QA committee recommendations. Full skin assessment will continue to be completed upon admission for an initial check.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		1/10/17

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F 272	Continued From page 3 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 272	Persons responsible: RAI Coordinators,	

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F 272	Continued From page 4 facility failed to comprehensively assess a residents skin care needs for 1 of 3 records (R125) who was reviewed for pressure ulcers. Findings include: R125's admission Minimum Data Set (MDS) assessment dated 8/23/16, identified R125 as having three stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intactor open/ruptured blister)pressure ulcers that were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. R125's medical record lacked any comprehensive assessment of R125's skin. A Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance dated 8/16/16, identified resident had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 pressure ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified both heels were "mushy". The Order Summary Report dated 8/17/16, indicated wound care to open area on coccyx twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP)	F 272	DON and/or designee It is the policy of St. Therese to complete the Admission Observation Assessment to provide a means for the interdisciplinary team to assess residents, plan and implement an individualized care plan, and evaluate the effectiveness of their care and treatment on an ongoing basis. This process is used to assist each resident to achieve/maintain an optimal functional level. The Admission Observation Assessment and "Resident Assessment and Care Planning" policy was reviewed on 12/19/16 by ADON of Indirect Care. 1. R125 passed away on 9/24/2016. DON reviewed the notes and the CAA was reviewed by the RAI Coordinator on 12/2/16. 2. Continue to complete an Admission Observation Assessment on all residents upon admission. A review of all current residents will be completed to ensure all residents have a completed Admission Observation Assessment on 12/23/16. Any corrective action will be addressed with staff as necessary. 3. Further education for all licensed staff on the Admission Observation Assessment process will be completed by 1/9/17. Clinical Coordinators and RAI Coordinators have had additional education on completing Care Area Assessments (CAAs)on 12/22/16. Attendance was taken and those not in attendance will complete education prior to next scheduled shift.	

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F 272	Continued From page 5 progress note dated 8/17/16, identified "facility nurses reported that pt [patient] has a wound on her buttocks that she will be evaluating once pt is laying back down in bed." During interview on 12/1/16, at 1:35 p.m. the director of nursing verified no comprehensive assessment had been completed and that the CAA should have been done.	F 272	4. A peer audit between RAI Coordinators and Clinical Coordinators starting 12/28/16 to ensure CAAs are sufficient as per CMS request. Random audits will be completed to ensure compliance and reported to the QI/QA committee for their recommendations. A total of 2 audits on each unit per week for a period of 30 days and/or until compliance is achieved as determined by the QI/QA committee and their recommendations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan for 1 of 5 residents (R229) reviewed for activities of daily living (ADLs), who was dependent upon staff for hygiene. Findings include: R229's diagnoses as indicated on the admission Minimum Data Set dated 8/29/16, included dementia and anxiety disorder. The Care Area Assessment for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor. R229's care plan, revised 11/23/16, identified	F 282	Persons responsible: Clinical Coordinators, DON, and/or designee It is the policy of St. Therese to complete the Admission Observation Assessment to provide a means for the interdisciplinary team to assess residents, plan and implement an individualized care plan, and evaluate the effectiveness of their care and treatment on an ongoing basis. This process is used to assist each resident to achieve/maintain an optimal functional level. The Admission Observation Assessment, "Resident Care: Grooming" policy and NA/R Care Audit were reviewed by ADON of Indirect Care	1/10/17

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F 282	Continued From page 6 R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning." During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven. During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. nursing assistant (NA)-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing, dressing, and with brushing teeth, after which R229 returned to bed. R229 was not shaved, nor was he offered assistance to shave, during the provision of cares. R229 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven. During interview on 11/30/16, at 1:46 p.m. nursing assistant (NA)-D said R229 was currently unshaven, and acknowledged R229 was not offered shaving this morning during his cares. NA-D said,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed."	F 282	on 12/19/16. NA/R Care Audit was updated to specifically add facial hair grooming. 1. Facial grooming was completed to R229 on 11/30/16 during HS cares. Utilize the NA/R Care Audit to assess cares for R229 once on the AM shift and once on the PM shift on 12/22/16. Per the results of the Care Audit, education on appropriate resident grooming will be provided at point of care. 2. Use NA/R Care Audit for random audits to ensure that grooming, specifically facial hair and nail care, is being completed. Six audits per unit per week for one month will be conducted or until compliance is achieved as determined by the QI/QA committee and their recommendations. 3. Reeducating nursing staff involved in direct patient care on "Resident Care: Grooming" policy will be completed by 1/9/17. Licensed staff will continue to complete a weekly skin assessment on each resident's bath day which will include assessing nail care, facial hair, and overall grooming. Re-education on completion of skin assessment started on 12/22/16. 4. The results of the random NA/R Care Audits will be reported to the QI/QA committee. Revisions made per QI/QA committee recommendations. Full skin assessment will continue to be completed upon admission for an initial check.	

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F 282	Continued From page 7 During an interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C said she would expect and trust the aides would at least offer to shave R229 every day, and if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and that R229 could be resistive to cares. She also stated "we should always, always" keep trying, and document refusals of care. During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) said he would expect the aides to follow their care guide and shave residents as needed. The DON also stated he expected the nurses in charge to monitor staff to ensure routine cares were completed. A facility policy, Resident Assessment and Care Planning, dated Feb 2014, indicated as its purpose "To provide a means ...to assess residents, plan and implement an individualized care plan."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming cares	F 312	Persons responsible: Clinical Coordinators, DON, and/or designee	1/10/17

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F 312	Continued From page 8 for 3 of 5 residents (R202, R229, R44) who were unable to perform grooming and personal hygiene without extensive staff assistance. Findings include: R202's quarterly Minimum Data Set (MDS) dated 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in the lounge area sitting with her daughter.	F 312	It is the policy of St. Therese that each NA/R will care for each resident as indicated on the care plan and Assignment Sheet. A review of the NA/R Care Audit and "Resident Care: Grooming", "Infection Control: Hand Hygiene" and "NA/R Care Observation Completion" policies on 12/19/16 by the ADON of Indirect Care. 1. Facial grooming was completed during HS cares on 11/30/16 for R229. Facial grooming for R202 was completed on 12/1/16 on PM shift. Nail care was provided to R44 on 12/1/16 on PM shift. Utilize the NA/R Care Audit to assess cares for R202, R229, and R44 once on the AM shift and once on the PM shift on 12/22/16 and 12/23/16. Per the results of the Care Audit, education on appropriate resident grooming will be provided as needed and any corrective action will follow if necessary. 2. Use NA/R Care Audit for random audits to ensure that grooming, specifically facial hair and nail care, is being completed. Six audits per unit per week starting on 12/23/16 for one month and/or until compliance is achieved as determined by the QI/QA committee and their recommendations. 3. Reeducating nursing staff involved in direct patient care on "Resident Care: Grooming" and "Infection Control: Hand Hygiene" policies starting on 12/23/16. Licensed staff will continue to complete a	

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F 312	Continued From page 9 R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on 11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this." During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands. During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing. During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed. During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.	F 312	weekly skin assessment on each resident's bath day which will include assessing nail care, facial hair, and overall grooming. Re-education on completion of skin assessment started on 12/22/16. Re-educating licensed nurses on hand washing procedure starting on 12/23/16. 4. The results of the random NA/R Care Audits will be reported to the QI/QA committee. Revisions made per QI/QA committee recommendations. Full skin assessment will continue to be completed upon admission for an initial check.	

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R229's admission MDS dated 8/29/16, included diagnoses of dementia and anxiety disorder. The MDS further indicated R229 had severe cognitive impairment, and required extensive assistance to complete personal hygiene. The Care Area Assessment (CAA) for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor.

R229's care plan, revised 11/23/16, identified R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning."

During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, an approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven.

During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. NA-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing, dressing, and brushing teeth, after which R229 returned to bed. R229

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was not shaved, nor was offered assistance to shave, during the provision of cares. R229 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven.

During interview on 11/30/16, at 1:46 p.m. NA-D stated R229 was currently unshaven, and acknowledged R229 was not offered shaving that morning during his cares. NA-D stated,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed."

During interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C stated she would expect and trust the nursing aides would at least offer to shave R229 every day, and further, that if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and R229 could be resistive to cares, but then stated "we should always, always" keep trying, and document refusals of care.

During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) stated he would expect the nurses aides to follow their care guide and shave residents as needed. The DON also said he expected the nurses in charge to monitor staff to ensure routine cares were completed.

R44's quarterly MDS dated 11/2/16, identified R44 had moderate cognitive impairment and required extensive assistance with personal hygiene.

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F 312	Continued From page 12 During observation on 11/28/16, at 3:02 p.m. R44 was seated in his wheelchair in the commons area. R44 had visibly long fingernails on all fingers of both his hands. R44 stated his nails were, "Really too long," and he would like them trimmed shorter, but, "Not too many people" help him to do it. During subsequent observations on 11/29/16, at 1:18 p.m. and 11/30/16, at 1:45 p.m. R44 continued to have long fingernails on both of his hands. R44's care plan dated 11/26/16, identified R44 required extensive assistance from staff to complete grooming tasks adding, "I am scared when it comes to clipping my nails so I like it if you talk me through it and explain to me what you are doing." During interview on 11/30/16, at 1:51 p.m. NA-A stated R44 was not resistive with cares and nail care was typically completed on during his weekly bath. At 1:54 p.m. NA-A observed R44's fingernails and stated they were, "Very long," and should have been clipped because it was part of providing good hygiene and so he, "Can't scratch himself or others." During interview on 11/30/16, at 2:00 p.m. LPN-A stated she observed R44's fingernails and they were, "A little bit long," and the nurse assigned to him on his last bath day should have clipped them. R44's Treatment Administration Record dated 11/2016, identified an intervention, "Trim finger/toe nails weekly with bath and PRN [as needed]." The record identified trimming of nails	F 312		

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F 312	Continued From page 13 had been completed two days prior to being observed with long fingernails by the surveyor on 11/26/16. A facility Resident Care: Grooming policy dated 1/2013, identified staff would, "...provide assist with grooming AM an PM according to resident needs." Further, the policy identified this included bathing, nail care, and shaving.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive assessment nor develop care plan interventions for 1 of 3 residents (R125) reviewed for pressure ulcers which resulted in actual harm for this resident. The facility also failed to consistently monitor a pressure ulcer for 1 of 3 residents (R68) reviewed for pressure ulcers R125's Admission Record dated 8/16/16, identified R125 was admitted on 8/16/16. The admission Minimum Data Set (MDS) dated	F 314	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	1/10/17

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F 314	Continued From page 14 8/23/16, identified R125 as being at risk for pressure ulcers and identified three, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) pressure ulcers. The MDS also identified R125 as needing extensive assistance of two staff with bed mobility. The Care Area Assessment worksheet (CAA) identified pressure ulcers as a triggering condition, however, the CAA did not analyze the findings/trigger nor did it develop any care plan considerations related to pressure ulcers. The Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance (tool used to determine appropriate repositioning needs) dated 8/16/16, identified R125 had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified was that both heels were "mushy." Review of the physician orders for 8/16/16, identified wound care to coccyx open areas 2 times per week and PRN, cleanse with wound cleanser and apply foam adhesive dressing. The Order Summary Report dated 8/17/16, identified wound care to open area on coccyx twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP)	F 314	Persons responsible: Clinical Coordinators, RAI Coordinators, DON and/or designee. It is policy of St. Therese to ensure that residents will not develop pressure sores unless the clinical condition demonstrates the pressure sore unavoidable and that necessary prevention and appropriate treatment be provided to promote healing. The "Skin Care Protocol" and "Pressure Ulcer Treatment" policies were reviewed and updated on 12/19/16 by the ADON of Indirect Care. To assure continued compliance the following plan has been implemented: 1. R125 passed away on 9/24/16; a care plan review, treatment record review, progress notes, and assessments were reviewed by the DON. CAA was reviewed by DON and RAI Coordinator. Dialogue with the respective hospice team concerning compliance about the hospice care plan aligning with St. Therese's care plan was completed. An audit was conducted on 12/22/16 on R68 to ensure compliance with standard of care for pressure ulcers. 2. Facility Wound Team and House Supervisor reviewed all current residents with pressure-related injuries to ensure a comprehensive assessment, care plan with interventions and consistent monitoring of wounds, is in compliance. The "Skin Ulcer Audit" was completed by	

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F 314	Continued From page 15 progress note dated 8/17/16, identified, "facility nurses reported that pt [patient] has a wound on her buttocks." The initial care plan dated 8/16/16, identified pressure ulcer with site being the coccyx related to edema. The care plan did not include any interventions to prevent worsening of the current pressure ulcers of the coccyx. The care plan did not identify any concerns with the heels. In addition, the record lacked evidence that the facility developed a comprehensive care plan during R125's stay at the facility. A hospice plan of care with a start date of 9/21/16, identified skin integrity-impaired (start date for this problem 8/11/16, 5 days before admission to the facility) secondary to mobility and nutritional deficit. Interventions identified assess actual/potential skin breakdown PRN starting 8/11/16, instruct on methods to prevent skin breakdown, RN instruct caregiver on methods to prevent skin breakdown. Wound care PRN starting 8/11/16. Hydrocolloid dressing to open area on coccyx, pressure relief cushion in wheelchair. The hospice care plan was not individualized and the facility did not develop a care plan individualized to R125's needs. The plan of care did not address the heels. Review of the weekly wound documentation on 8/16, 8/24, 8/31, 9/7, 9/13 and 9/14/16, identified pressure area to coccyx measuring 0.4 cm by 0.4 cm by 0.1 cm, stage 2. In addition, two other very small stage 2 pressure areas above one documented - these measure 0.2 cm x 0.2 cm. Treatment plan: wound care to coccyx open areas 2 times per week and as needed (PRN). Cleanse with wound cleaner and apply adhesive	F 314	12/22/16. Findings were collected and reviewed and any necessary revisions were made. St. Therese will continue to complete all of the assessments included in the protocol upon admission, quarterly, annually, and with status change for all residents to determine care strategies related to the potential of skin breakdown. As determined through assessment; interventions will be implemented to manage individual resident's needs. 3. Further education for all licensed staff on the Admission Observation Assessment process, Skin Care Protocol and Pressure Ulcer Treatment policies and procedures will be conducted by 1/9/17. Clinical Coordinators and RAI Coordinators will be re-educated on completing Care Area Assessments (CAAs) by 1/9/17. Pressure Injury Prevention Audit Tool will be initiated by 12/28/16 and random units completed 2 per unit, per shift, per day for a period of 90 days or as determined by the QI/QA committee. The results of these audits will be reported to the QI/QA committee and revisions will be made per QI/QA committee recommendations. Verify that all current hospice patients' care plans align with St. Therese care plans. Monitor for individualization in care planning process. 4. Perform "Hospice/St. Therese Care Plan" audits on all residents on hospice to verify that hospice and St. Therese care plans align by 1/9/17. Random audits will be conducted, 1 per week, per unit for 30	

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F 314	Continued From page 16 dressing. No other interventions were identified. The documentation identified the NP had been notified on 8/16/16 of the pressure ulcers. The weekly wound documentation did not address "mushy" area to heels, nor any treatment/interventions. A hospice note from 9/8/16, identified coccyx area as being red, almost purple. Not opened. Dressing on right heel with left heel being red and not open. A hospice note dated 9/9/16, identified, "staff reports coccyx area is closed and purple." However, this is conflicting to the weekly wound documentation which does address healing of the pressure ulcers. A nursing note dated 9/8/16, identified that the wound team was asked to observe R125's coccyx area. The team observed a .7 cm by 1.1 cm skin tear to the left side over the PSIS (posterior superior iliac spine) with what appeared as a hematoma with purple bruising underneath at noon to 3 and at 5 o'clock. Redness measured 2.2 cm by 4.5 cm. The wound team felt that area was not related to pressure but more of friction on skin causing a skin tear. A nursing note on 9/13/16, indicated intact blister on right heel and that heels were mushy upon admission. Interventions to include, heel manager and dressing to heel. A follow up note on 9/13/16, indicated NP was there with resident. New order for coccyx wound. Order included left heel boggy, use heel manager and float, reposition every 2 hours, right heel has intact blister, left buttocks new order for dressing change. A 9/13/16, progress note from the nurse	F 314	days. The results of these audits will be reported to the QI/QA committee and revisions will be made per QI/QA committee recommendations. Ongoing monitoring of pressure related injuries is noted in section 3 above.	

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practitioner (NP) identified R125 was being seen for concerns of skin integrity issues per the facility nurse. A physical exam identified an intact blister noted on the right heel measuring 2.2 cm by 2 cm and a 100% eschar (composed of necrotic granulation tissue, muscle, fat, tendon or skin) covered wound noted on the left buttocks 2.5 cm by 1 cm. as well as small clean open area noted on the coccyx measuring 0.2 cm by 0.2 cm.

The assessment plan from the NP was as follows:

1. Pressure ulcer of heel, right stage 2:
Patient had a foam dressing on right heel. When dressing removed an intact blister was noted on the heel. The facility nurse was unaware of this concern and unsure of when it was noted. Orders for wound care were cleanse with wound cleanser, pat dry, apply foam dressing, change on bath day and PRN if drainage or dislodgement. Heels to be floated while in bed and heel protectors on while up in wheelchair.

2. Pressure ulcer left buttock:
Unstageable (tissue loss in which the base of the ulcer is completely covered by slough (tissue that is light colored soft and moist) and/or eschar (black or brown or dead tissue) in the wound bed. Upon examination a 100% eschar covered wound was noted on the left buttocks. The facility nurse was unaware of this sore and unsure of when this occurred. No dressing was noted on the sore. Orders for wound care were to cleanse with wound cleanser, pat dry, apply calcium alginate dressing and change on bath day and PRN for drainage and dislodgement, turn and reposition every 2 hours both while in bed an in wheelchair and pressure reduction mattress and cushion for

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F 314	Continued From page 18 wheelchair. 3. Pressure ulcer, coccyx, stage 2: This was a known pressure ulcer. The ulcer was noted to be clean with no signs of infection. The wound was identified as having depth but unable to measure due to the small size of the wound. Orders included house barrier cream with zinc every shift and PRN, turn and reposition every 2 hours both while in bed and in wheelchair and pressure reduction mattress and cushion for wheelchair. The weekly wound documentation on 9/14/16, identified a weekly wound documentation and identified the following: - blister to the right heel first identified on 9/13/16. - stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0 to coccyx, and another to coccyx identified stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0, - pressure ulcer to left side of buttocks, 100% eschar - unstageable pressure ulcer (tissue loss in which the base of the ulcer is completely covered by slough, and/or eschar. R125 was seen by the physician on 9/16/16, and no changes were made to the treatment plan that was developed by the NP on 9/13/16. R125 passed away on 9/24/16. During interview on 11/30/16, at 12:35 p.m. registered nurse (RN)-B verified no care plan had been developed and interventions implemented to prevent the worsening of R125's pressure ulcers until 9/13/16. During interview on 12/1/16, at 1:35 p.m. the director of nursing (DON) stated there should	F 314		

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have been interventions implemented upon admission and ongoing. He stated the first thing they should look at is the mattress, if it is the correct one for pressure areas as well as repositioning, cushions, nutritional interventions. DON stated the interventions should have been looked at weekly to see if they were effective and updated as needed. He verified that R125's pressure ulcers worsened and interventions had not been implemented to prevent them from worsening.

During interview on 12/12/16, at 2:30 p.m. the nurse practitioner (NP)-A stated R125 was admitted with a known stage 2 coccyx pressure ulcer. She stated that she did not visualize the stage 2 pressure ulcer on the day of admission, this was deferred. NP-A stated she did not know about R125's heels being mushy or about the other pressure ulcer on R125's buttocks. She stated that she was requested to look at R125 on 9/13/16, per the wound team. She stated at this time she observed a stage 2 pressure ulcer to the heel (it was a blister) and an unstageable ulcer to the buttocks as well as the stage 2 ulcer to the coccyx. She stated there was no dressing on the unstageable area and the heel had been covered with a dressing. She stated the facility nurse was unaware of both of these areas. She stated the 13th of September was the first she observed the areas, and verified the heel and buttocks had worsened.

The facility policy Pressure Ulcer Treatment dated November 2016, identified the following protocol:

Stage I protocol
1. Pressure:

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F 314	Continued From page 20 a. Determine cause of pressure and relieve; b. Redistribute pressure and interventions to off-load, if indicated; c. Implement pressure-relieving device(s) in accordance with resident's assessed needs; d. Evaluate until redness is no longer persistent; e. Persistent redness is determined only after pressure has been relieved for at least 3/4 of the time it was applied and the redness remains (for example: if resident had been on side for two hours (120 minutes), reposition/off load area and re-evaluate site/area in 90 minutes to determine if area has resolved); f. Notify physician, family and appropriate facility personnel and document communication in medical record and g. Generate wound assessment and complete. h. Obtain new treatment order if indicated. 4. Immobility: a. Turn Schedule; and b. Restorative nursing (range of motion, walking, bed mobility). Evaluate and determine pain level with pain assessment. Stage II Protocol..... Follow-up If wound does not improve in 2-3 weeks, notify physician. Re-evaluate nutritional support, off-loading/redistribution devices and advanced wound product changes.	F 314		

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F 314	Continued From page 21 R68's admission Minimum Data Set (MDS), dated 11/20/16, indicated no cognitive impairment and the presence of a Stage 1 pressure ulcer (area of unopened nonblanchable redness) on admission. R68's pressure ulcer Care Area Assessment (CAA), dated 11/23/16, identified a "nonblanchable redness to her R (right) buttock." The CAA indicated R68's right buttock was being monitored daily for changes. Review of R68's facility "progress notes" indicated the following: - On 11/13/16, at 2:32 p.m. R68's admission documentation identified redness to the buttocks. Later that day, at 9:53 p.m. a scabbed area was noted on the right buttock measuring 1.5 cm (centimeters) x (by) 0.6 cm. - On 11/14/16, at 3:07 a.m. R68's buttocks was identified as "fragile but intact" indicating the facility's wound team would evaluate and treat the stage 1 pressure ulcer. - On 11/22/16, at 12:54 p.m. R68's right buttock was observed with a "superficial open area of maceration to wound edges." No measurements were documented. - On 11/24/16, at 11:28 a.m. R68's right buttock was observed with a small open area measuring 1 cm x 0.8 cm. The note did not describe the wound bed. - On 11/25/16, 11/26/16, and 11/27/16, R68's right buttock dressing was changed, however, the wound bed was not described. - On 11/30/16, at 3:13 p.m. R68's right buttocks dressing was changed and was "Noted to be improving," however, the wound measured 5.5 cm x 2.5 cm x 0.3 cm deep. The note classified the wound as "In between stage 1 and 2."	F 314		

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F 314	Continued From page 22 R68's progress notes lacked daily monitoring of the pressure ulcer. R68's first Weekly Wound Documentation assessment, dated 11/28/16, indicated the pressure ulcer was first identified on 11/13/16. The assessment indicated R68's right buttock had increased to a stage 2 pressure ulcer measuring 2 cm x 1.5 cm x 0.3 cm deep with a wound bed consisting of 75% (percent) granulation (healthy) tissue and 25% slough (necrotic tissue that doesn't promote healing). In addition, the assessment indicated R68 had developed a new stage 2 pressure ulcer on the left buttock measuring 1 cm x 0.5 cm x 0.2 cm deep consisting of 75% granulation tissue and 25% slough. Both assessments were inconsistent with R68's progress notes and the previous staging of R68's pressure ulcer. R68's temporary care plan, undated, directed to "Monitor pressure ulcer to R buttock daily" and "Document weekly on status of ulcer." It did not identify a pressure ulcer on the left buttock. During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-B changed R68's dressing to right buttock. After removing the soiled dressing, LPN-B stated R68's right buttock looked much better, the wound bed was superficial, consisting of healthy tissue, did not contain slough, and was surrounded by reddened peeling skin. LPN-B measured the pressure ulcer as 5.5 cm long x 2 cm wide. LPN-B was observed to measure the length from the open area of the ulcer on R68's lower buttock up to the area of intact reddened skin on the upper buttock (the periwound). LPN-B did not measure the length	F 314		

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from open end to open end of the ulcer nor did she measure the depth of the ulcer during the observation. In addition, LPN-B observed R68's left buttock and stated the skin was healed and intact.

During interview on 11/30/16, at 11:56 a.m. LPN-B stated the right buttock had an area in the middle (the pressure ulcer) that looked slightly deeper than the reddened superficial skin around it; however she "Put it all together" measuring it all as one.

During observation on 12/1/16, at 9:31 a.m. registered nurse (RN)-C performed wound cares and measured right buttock pressure ulcer 1.1 cm x 1.5 cm x 0.4 cm deep. RN-C stated the pressure ulcer was superficial and did not contain slough. In addition, RN-C stated the skin around the pressure was reddened, dry, and peeling, but would still be considered the periwound. RN-C stated R68's left buttock contained blanchable redness and was intact.

During interview on 12/1/16, at 11:01 a.m. RN-C stated R68's pressure ulcer had been observed on 11/22/16 by the wound team when it had opened and progressed to a stage 2. RN-C stated the right buttocks was healing and the measurements for the previous day, on 11/30/16, were incorrect, further stating the wound bed should be measured separately from the periwound. RN-C stated R68 had never had a pressure ulcer on the left buttocks, further stating the wound assessment from 11/28/16 was incorrect.

During interview on 12/1/16, at 11:47 a.m. RN-D stated the floor nurses were responsible for

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F 314	Continued From page 24 monitoring pressure ulcers daily and charting weekly with measurements. RN-D stated the daily monitoring should consist of the drainage, odors, how the wound bed looks, and if there are any changes. RN-D stated inconsistencies in measuring pressure ulcers was an ongoing issue. RN-D reported wound measurements, assessments, and monitoring needed to be accurate to ensure the right treatment is ordered and to prevent infections. A facility policy entitled Skin Care Protocol, dated 4/10, directed nurse managers or designee to "Document the assessment status weekly on the Weekly Wound Documentation" and specifically directed staff to perform daily monitoring of pressure ulcers, which included "Evaluation of the ulcer if no dressing present, evaluation of dressing, status of surrounding area, and presence of possible complications."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R337) identified to be currently smoking while at	F 323	Persons responsible: Social Services, Clinical Coordinators, RAI Coordinators, DON and/or designee.	1/10/17

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F 323	Continued From page 25 the facility. Findings include: R337's admission Minimum Data Set (MDS) dated 11/16/16, identified R337 had intact cognition. R337's Transitional Care Follow-Up Visit note dated 11/22/16, identified R337 was residing in the transitional care unit at the facility. The note identified several diagnoses which included, "Tobacco use disorder," with further dictation identifying, "Nursing staff report that patient sometimes goes out to smoke." During observation on 12/1/16, at 7:55 a.m. R337 was seated on her electric scooter coming up from the street to the main outside entrance to the facility. R337 was dressed in a light sweater and had no oxygen in place. When interviewed on 12/1/16, at 7:58 a.m. the receptionist (RCP)-A stated R337 goes outside to smoke and has to go down by, "Bass Lake Road," because she was not allowed to smoke on campus. R337's progress notes identified the following entries: - On 11/9/16, "...she [R337] refused to eat supper until she could go outside and have a cigarette." - On 11/10/16, "...spoke to resident about the risks of smoking and using butane lighter while using oxygen...made promise not to smoke." - On 11/16/16, "...resident able to wheel self and went outside..." - On 11/29/16, "...spoke with resident on this date regarding smoking outside on campus ... stated	F 323	It is the policy of St. Therese to create an environment that focuses on the safety of all residents. St. Therese continues to maintain a smoke-free campus. 1. R337 has been discharged on 12/2/2016. 2. Residents who actively participate in smoking will continue to be identified upon admission during the initial interview completed by Social Services. Nursing will incorporate questions to identify residents who smoke in the Admission Observation Assessment. The Admission Observation Assessment was revised and implemented on 12/23/16. A review of all current residents was completed to identify and assess any other smokers in the facility and their safety with smoking. 3. St. Therese implemented a smoking assessment to ensure resident safety while smoking off campus that will be completed for all residents who smoke on. 4. Social worker, RAI Coordinator, and Clinical Coordinator will verify that residents who smoke have been identified and that the assessments and interventions have been completed. This will be completed through IDT audits. An audit will be completed on all new admissions for the duration of one month and will be reported to the QI/QA Committee for recommendations.	

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she [R337] is aware of this and that she is planning to take her electric scooter down to Bass Lake Road to smoke. Writer stated that we do not recommend she do that..."

R337's medical record was reviewed and lacked any identified comprehensive assessment to ensure R337 was safe to smoke without supervision, to determine if any interventions were required to ensure her safety with unsupervised smoking while off campus.

R337's care plan dated 11/11/16, identified R337 was a smoker and, "Pt [patient] aware facility is non-smoking." The plan listed a goal for R337 to have decreased respiratory health complaints and listed interventions which included instructing R337 to have friends or family with her while smoking and to keep lighter in safe area away from oxygen tanks.

During interview on 12/1/16, at 8:24 a.m. R337 stated she had been outside smoking that morning when the surveyor had observed her coming inside. She adding she goes out to smoke multiple times a day. R337 stated she goes, "Down by the street [Bass Lake Road]," to smoke. R337 stated she has her own lighter and cigarettes in the room, but no longer uses oxygen. R337 stated family will sometimes go with her if they are present, but she often goes by herself. Further, R337 stated she felt safe smoking on her own adding no staff had ever gone outside to observe her smoke or talked with her about her ability to smoke on her own.

During interview on 12/1/16, at 8:59 a.m. nursing assistant (NA)-K stated R337 goes out to smoke several times during her shift by herself, "She

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F 323	Continued From page 27 don't tell us about it." NA-K stated she felt R337 was safe to smoke on her own because she could dress herself, "I think she can do it." During interview on 12/1/16, at 9:03 a.m. registered nurse (RN)-F stated R337 goes outside on her own at times adding staff suspected she was smoking because she often smells like smoke when she comes back inside. RN-F stated R337 had a lighter when she admitted to the nursing home, however staff told her it was a non-smoking campus and it was removed. RN-F stated she was unaware if R337 had ever been assessed for her safety with unsupervised smoking, however, added it would be a good thing to do because R337, "Could burn herself" potentially if she was smoking and were to drop it or have a problem. During interview on 12/1/16, at 10:31 a.m. registered nurse (RN)-D stated R337 had been smoking while in the facility since her admission and being warned, "Several times" about smoking right outside the front doors and not signing herself out when she goes outside consistently. RN-D stated R337 had never been comprehensively assessed for safety with her smoking because it was a tobacco free campus, however, added R337 should have been assessed to ensure she was safe to smoke unsupervised because she could potentially start a fire or burn herself. Further, RN-D stated the facility did not have a smoking safety policy as it was, "In progress."	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		1/10/17

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F 356	Continued From page 28 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required daily staffing information in a prominent place where it could be easily reviewed. This had potential to affect all 219 residents, visitors and staff who wished to review the information.	F 356	Persons responsible: Staffing personnel, Receptionist, DON and/or designee. It is the policy of St. Therese to ensure that staffing information is accessible to all residents, visitors, and staff. The "Staffing: Posting of Nursing Hours" policy	

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F 356	Continued From page 29 Findings include: During a tour of the facility on 11/29/16, at 1:05 p.m. the main entrance had a framed document sitting on top of a dresser which identified, "The most recent survey results and staffing hours are located in a marked binder at the end of the main lobby." At the opposite end of the main lobby a closed white binder was placed on a small desk which was labeled to contain past survey results and, "Posted Daily Staffing," information. The required staffing information was contained in the closed white binder behind the cover. There were no further posted documents to identify the facility staffing hours in the main lobby. During subsequent observation on 11/30/16, at 1:41 p.m. the required daily staffing information was again contained in the closed white binder on the desk in the main lobby. There were no further posted documents to identify the facility staffing hours in the main lobby. When interviewed on 11/30/16, at 2:16 p.m. staffing supervisor (SS)-A stated the posting is placed in the binder for each shift with three different people changing it on a daily basis. SS-A stated she was unaware why the staffing information was contained in a binder and not posted for residents and visitors to easily review, adding it had been placed in the white binder for the past several months. During interview on 11/30/16, at 2:30 p.m. the administrator stated the facility had been placing the staffing information in the binder for, "Years," and she was unaware it should be posted to be visible for residents and visitors to easily review.	F 356	has been reviewed on 12/19/16 and changes made as necessary by ADON of Indirect Care. 1. No known residents were directly impacted by the location of the nurse staffing information posting. 2. No known visitors were directly impacted by the location of the nurse staffing information posting. 3. Nursing staffing hours are posted in a location and height that is accessible to all residents, visitors, and staff. The hours are no longer kept in a binder as of 12/23/16. Education for all departments regarding posted staffing information will be completed by 1/9/17. 4. Random audits will be conducted daily for one month, to ensure nursing hours are posted accessibly beginning 12/23/16.	

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F 356	Continued From page 30 A facility Nursing House Posting policy dated 8/2011, identified a purpose of posting the hours, "Per the regulation," and directed staff to post the required hours, "...in white 3 ring binder across from Clinical Directors office." No further information was provided.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a sanitary kitchen environment with unclean mixing bowls stored uncovered and on the floor for 1 of 2 production kitchens which served meals to 216 of 216 residents who receive food from this kitchen Findings include: During observation of the residence kitchen on 11/28/16, at 10:32 a.m. two large standing mixers and three large metal mixing bowls were observed uncovered and stored on the floor while not in use. One large metal bowl was resting on a	F 371	It is the practice of St. Therese to prepare, store, distribute and serve food under sanitary conditions. 1. No known residents were affected by this practice. 2. No known residents were affected by this practice. 3. The mixing bowl storage procedure has been updated. New 40-60 bowls storage procedure was put in to place. The process now is to cover clean, dry mixing bowls with a clean food service bag and not use food service film. On 12/10/16 two additional mixing bowl trucks (bowl	1/10/17

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F 371	Continued From page 31 round metal rolling stand under a standing mixer. The bowl was uncovered and several brown crumbs were observed in the bottom of the bowl. During observation, dietary manager (DM)-A removed the bowl, handed it to a dietary staff member, and instructed them to clean out the crumbs stating the crumbs must have fallen in the bowl during meal preparation from a nearby counter. The second standing mixer was observed with a white liquid substance splattered on the bottom of the mixer. Next to the mixer, two metal mixing bowls, one on top of the other, were sitting directly on the ground. The same white liquid substance was splattered along the bottom and sides of the both mixing bowels. Neither bowl was covered. During interview on 11/28/16, at 10:32 a.m. DM-A stated the white substance on the mixer and bowls was from making mashed potatoes. DM-A stated the staff use the mixers "All the time," and tried to "Wipe them down as needed" during the day. DM-A further stated the mixers should be cleaned once a day and were not stored covered when not being used. During observation on 12/1/16, at 10:14 a.m. only two mixing bowls were present in the kitchen. The mixing bowls were observed off the floor resting on round metal rolling stands and were observed covered with clear plastic cling wrap. A white liquid substance was observed splattered on the top of the cling wrap. During interview on 12/1/16, at 10:14 a.m. cook (C)-A stated the metal mixing bowls were not usually stored covered with the cling wrap and were only sometimes stored on the rolling stands.	F 371	dollies) were purchased, to help with proper storage. Staff training was started and documented on 12/19/16 for proper storage of mixing bowls. 4. Audit sheets were made to audit clean storage of mixing bowls. Audits will be done two times per week for 3 months starting on 12/22/16.	

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F 371	Continued From page 32 During interview on 12/1/16, at 10:19 a.m. DM-A stated food "Gets flung around so much" pointing to the top of the cling wrap and furthered stated there were mashed potatoes on the top of it. DM-A further stated mashed potatoes were made twice everyday and she had placed the clear cling wrap over the bowls thinking "That was safer to keep it covered, that was my fix for it." A facility policy entitled Storage of 60 Quart Mixing Bowls, undated, directed staff to place the bowls on the "Wheel dollies" for easy moving and to "Cover clean bowls with food service film, to help prevent items from falling into bowls, prevent infection and maintain cleanliness of the bowls."	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		1/10/17

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F 441	Continued From page 33 isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was followed for 1 of 1 residents (R68) observed during wound cares. Findings include: R68's admission Minimum Data Set (MDS) dated 11/20/16, indicated the presence of a pressure ulcer (open wound related to pressure.) During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-placed a pair of gloves on her hands and did not wash her hands prior to donning. She then placed another pair of gloves over the already gloved hands. LPN-B removed R68's soiled dressing. After removing the soiled dressing, LPN-B stated it contained a small amount of serous (pale yellow color) drainage from R68's wound. LPN-B discarded the	F 441	Persons responsible: ADON of Indirect Care and/or designee It is the policy of St. Therese to utilize proper hand washing and gloving while conducting procedures. Our "Infection Control: Use of Gloves" and "Infection Control: Hand Hygiene" policies have been reviewed by ADON of Indirect Care. 1. No adverse outcome was noted for R68. 2. A scenario/audit will be presented to a randomly selected group of licensed nurses involving wound care and gloving procedure. This data will be reported to the QI/QA committee. This will occur during all shifts/all units everyday for 30 days. Any corrective action will be	

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F 441	Continued From page 34 soiled dressing, washed, dried, and measured R68's wound then removed one of the two pairs of gloves. LPN-B proceeded to open the new dressing while wearing the second pair of potentially contaminated gloves and placed the new dressing over R68's wound. LPN-B stated her hands should have been washed immediately before donning gloves and would usually wash in between changing the dirty and clean dressings. LPN-B further stated it was her routine to double glove and not the facility's policy. During interview on 12/1/16, at 11:47 p.m. registered nurse (RN)-D stated gloves should be removed and changed in between dirty and clean dressings. RN-D further stated it was not the facility's policy to double glove and staff received education on proper hand hygiene during wound care in orientation and annually. During interview on 12/1/16, at 2:46 p.m. RN-E stated "The use of double gloving is not appropriate" and was not taught by the facility. RN-E further stated the observation provided an "Opportunity for re-education." The facility policy Infection Control: Use of Gloves dated 1/05, directed staff to change gloves in between tasks on the same resident after Contact with material that may contain a high concentration of microorganisms. It further directed staff to remove gloves before touching non-contaminated items. The facility policy Infection Control: Hand Hygiene dated 2/10, directed staff to perform hand hygiene prior to application and upon removal of gloves.	F 441	immediately addressed with staff at the point of care, if necessary, until compliance is achieved as determined by the QI/QA committee and their recommendations. 3. Educate licensed nurses and NA/Rs on the two policies mentioned above and reinforce the expectation that the facility's policies need to be followed. This formal training on these policies will be completed by 1/9/17. 4. Complete random "Gloving" audits on licensed nurses for proper gloving and dressing changes. These will be conducted randomly on each shift/each unit for 30 days. Any corrective action will be immediately addressed with staff at the point of care, if necessary, until compliance is achieved as determined by the QI/QA committee and their 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 _____	12/01/2016

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 465	Continued From page 35	F 465		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a sanitary kitchen environment with dirty wall fans for 1 of 2 production kitchens which has the potential to effect 216 of 216 residents that receive meals from this kitchen. finding include: During observation of the residence kitchen on 11/28/16, at 10:32 a.m. two wall mounted fans were observed on and blowing in the dishwashing area. One mounted fan was observed blowing toward the clean side of the dish area where a three tier metal rolling cart stood. During observation, two racks of clean dishes, containing serving utensils and clear plastic jugs, came out of the dishwasher on a conveyor belt toward the fan. When turned off, the wire rings of the fan were covered with hanging thick gray fuzz extending from the middle to the back of the fan. During interview on 11/28/16, at 10:32 a.m. DM-A stated the thick gray substance "Looks like fuzz" and the fan "Needs to be cleaned." DM-A stated maintenance took apart the fans and cleaned them once a month but that one "Must've been missed." DM-A further stated the cleaned wet	F 465	It is the practice of St. Therese to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. No known residents were harmed by this practice. 2. No known residents were harmed by this practice. 3. The Plant Operations department preventative maintenance program for fan cleaning was updated to include fan disassembly. The new date for monthly disassembly of the fans will be the last Wednesday of each month. This information was put in Outlook calendars to help remind staff about monthly cleaning of wall fans. The cleaning of wall fans procedure has been updated. Staff training about proper monthly wall fan cleaning has been started. Wall fan cleaning audits have been created. Audits will be conducted monthly for 6 months; this is in Outlook calendars to do the audits monthly.	1/10/17

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 _____	12/01/2016

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 465	Continued From page 36 dishes were stored on the the metal cart in the afternoon to dry then put away at night. During observation on 12/1/16, at 10:14 a.m. the fan was observed cleaned without any gray fuzz. During interview on 12/1/16, at 10:19 a.m. DM-A stated that particular fan was different than the others and couldn't be taken apart to be cleaned. DM-A states "I wouldn't say it got missed, I'd say it only got half done," as staff had to climb up to clean the fan. DM-A further stated she would expect staff to remember that fan needs to be cleaned differently when completing the task. A facility policy entitled Cleaning of Wall Fans, undated, directed maintenance to remove the fan guards monthly; however, the policy directed the dietary staff to wipe off dust and dirt build up and wash the fan guards. The policy further directed "Clean fans help prevent dust being moved onto food and food service equipment." A facility document entitled Completed Work Orders-Tasks indicated the fans had been serviced on 11/10/16.	F 465		

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 _____	**11/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 30, 2016. At the time of this survey, St. Therese Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 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		12/23/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	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 west-side of the 1st floor that was determined to be of Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an exiting building, the building is surveyed as one building. The building is fully fire sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 258 beds and had a census of 219 at	K 000		

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 _____	**11/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=E	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 observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all residents on the first and second floor. Findings include: On a facility tour between the hours of 1000 and 1530 on November 30, 2016, observations revealed that the heating, ventilation and air conditioning systems for the first and second floor of the 1968 building are using the corridor system as part of the air distribution system as a return air plenum through the bathroom exhaust. This deficient practice was verified by the plant operations manager at the time of inspection.	K 521	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 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 the current reimbursement rates, we estimate that it 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	12/23/16

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 _____	**11/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 3	K 521	feet, the addition of ducts and ceiling materials would reduce the headroom to less than 6'5". The building is currently 48 years old and strategic planning for the organization has begun for the future of this building. B: There will be no adverse effect on the building occupants safety in accordance with SOM2480B, because Saint 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. 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 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	

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 _____	**11/30/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 4	K 521	from the MN Fire Marshall office. The facility staffing ratio is 1 staff per 1.3 residents in a 24 hour hour period.	

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)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	State Fire Marshal Division	01-23-2017

Name of Facility		2012 LIFE SAFETY CODE
	St. Therese Home	

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 01-23-2017

UHL COMPANY
SINCE 1917
www.uhlcompany.com
763 • 425 • 7226
9065 ZACHARY LANE N
MAPLE GROVE, MN 55369

April 8, 2014

St Therese
8000 Bass Lake Road
New Hope, MN 55428

Attention: Rick Campbell

Dear Rick:

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

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

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

Sincerely,
Uhl Company, Inc.

Roy H. Jensen
Account Manager

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
December 15, 2016

Ms. Dinah Martin, Administrator
St. Therese Home
8000 Bass Lake Road
New Hope, MN 55428

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5518027

Dear Ms. Martin:

The above facility was surveyed on November 28, 2016 through December 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	12/01/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	12/01/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28th 2016, through December 1st 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. An investigation of complaint H5518070 was completed and found not to be substantiated. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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	00261	A. BUILDING: _____ B. WING _____	12/01/2016

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

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		1/10/17

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess a residents skin care needs for 1 of 3 records (R125) who was reviewed for pressure ulcers. Findings include: R125's admission Minimum Data Set (MDS) assessment dated 8/23/16, identified R125 as having three stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intactor open/ruptured blister)pressure ulcers that were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. R125's medical record lacked any comprehensive assessment of R125's skin. A Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance dated 8/16/16, identified resident had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 pressure ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified both heels were "mushy". The Order Summary Report dated 8/17/16, indicated wound care to open area on coccyx	2 540	These orders have been reviewed and will be corrected	

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2 540	Continued From page 4 twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP) progress note dated 8/17/16, identified "facility nurses reported that pt [patient] has a wound on her buttocks that she will be evaluating once pt is laying back down in bed." During interview on 12/1/16, at 1:35 p.m. the director of nursing verified no comprehensive assessment had been completed and that the CAA should have been done. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		1/10/17

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2 565	Continued From page 5 Based on observation, interview, and document review, the facility failed to implement the care plan for 1 of 5 residents (R229) reviewed for activities of daily living (ADLs), who was dependent upon staff for hygiene. Findings include: R229's diagnoses as indicated on the admission Minimum Data Set dated 8/29/16, included dementia and anxiety disorder. The Care Area Assessment for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor. R229's care plan, revised 11/23/16, identified R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning." During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven. During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. nursing assistant (NA)-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing,	2 565	These orders have been reviewed and will be corrected	

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2 565	Continued From page 6 dressing, and with brushing teeth, after which R229 returned to bed. R229 was not shaved, nor was he offered assistance to shave, during the provision of cares. R229 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven. During interview on 11/30/16, at 1:46 p.m. nursing assistant (NA)-D said R229 was currently unshaven, and acknowledged R229 was not offered shaving this morning during his cares. NA-D said,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed." During an interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C said she would expect and trust the aides would at least offer to shave R229 every day, and if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and that R229 could be resistive to cares. She also stated "we should always, always" keep trying, and document refusals of care. During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) said he would expect the aides to follow their care guide and shave residents as needed. The DON also stated he expected the nurses in charge to monitor staff to ensure routine cares were completed. A facility policy, Resident Assessment and Care Planning, dated Feb 2014, indicated as its purpose "To provide a means ...to assess residents, plan and implement an individualized care plan."	2 565		

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2 565	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R337) identified to be currently smoking while at the facility. Findings include:	2 830	These orders have been reviewed and will be corrected	1/10/17

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2 830	Continued From page 8 R337's admission Minimum Data Set (MDS) dated 11/16/16, identified R337 had intact cognition. R337's Transitional Care Follow-Up Visit note dated 11/22/16, identified R337 was residing in the transitional care unit at the facility. The note identified several diagnoses which included, "Tobacco use disorder," with further dictation identifying, "Nursing staff report that patient sometimes goes out to smoke." During observation on 12/1/16, at 7:55 a.m. R337 was seated on her electric scooter coming up from the street to the main outside entrance to the facility. R337 was dressed in a light sweater and had no oxygen in place. When interviewed on 12/1/16, at 7:58 a.m. the receptionist (RCP)-A stated R337 goes outside to smoke and has to go down by, "Bass Lake Road," because she was not allowed to smoke on campus. R337's progress notes identified the following entries: - On 11/9/16, "...she [R337] refused to eat supper until she could go outside and have a cigarette." - On 11/10/16, "...spoke to resident about the risks of smoking and using butane lighter while using oxygen...made promise not to smoke." - On 11/16/16, "...resident able to wheel self and went outside..." - On 11/29/16, "...spoke with resident on this date regarding smoking outside on campus ... stated she [R337] is aware of this and that she is planning to take her electric scooter down to Bass Lake Road to smoke. Writer stated that we do not recommend she do that..."	2 830		

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2 830	Continued From page 9 R337's medical record was reviewed and lacked any identified comprehensive assessment to ensure R337 was safe to smoke without supervision, to determine if any interventions were required to ensure her safety with unsupervised smoking while off campus. R337's care plan dated 11/11/16, identified R337 was a smoker and, "Pt [patient] aware facility is non-smoking." The plan listed a goal for R337 to have decreased respiratory health complaints and listed interventions which included instructing R337 to have friends or family with her while smoking and to keep lighter in safe area away from oxygen tanks. During interview on 12/1/16, at 8:24 a.m. R337 stated she had been outside smoking that morning when the surveyor had observed her coming inside. She adding she goes out to smoke multiple times a day. R337 stated she goes, "Down by the street [Bass Lake Road]," to smoke. R337 stated she has her own lighter and cigarettes in the room, but no longer uses oxygen. R337 stated family will sometimes go with her if they are present, but she often goes by herself. Further, R337 stated she felt safe smoking on her own adding no staff had ever gone outside to observe her smoke or talked with her about her ability to smoke on her own. During interview on 12/1/16, at 8:59 a.m. nursing assistant (NA)-K stated R337 goes out to smoke several times during her shift by herself, "She don't tell us about it." NA-K stated she felt R337 was safe to smoke on her own because she could dress herself, "I think she can do it." During interview on 12/1/16, at 9:03 a.m.	2 830		

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2 830	Continued From page 10	2 830		

registered nurse (RN)-F stated R337 goes outside on her own at times adding staff suspected she was smoking because she often smells like smoke when she comes back inside. RN-F stated R337 had a lighter when she admitted to the nursing home, however staff told her it was a non-smoking campus and it was removed. RN-F stated she was unaware if R337 had ever been assessed for her safety with unsupervised smoking, however, added it would be a good thing to do because R337, "Could burn herself" potentially if she was smoking and were to drop it or have a problem.

During interview on 12/1/16, at 10:31 a.m. registered nurse (RN)-D stated R337 had been smoking while in the facility since her admission and being warned, "Several times" about smoking right outside the front doors and not signing herself out when she goes outside consistently. RN-D stated R337 had never been comprehensively assessed for safety with her smoking because it was a tobacco free campus, however, added R337 should have been assessed to ensure she was safe to smoke unsupervised because she could potentially start a fire or burn herself. Further, RN-D stated the facility did not have a smoking safety policy as it was, "In progress."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff and monitor to ensure all residents were assessed for safety related to smoking. The DON could educate all staff on these systems. The DON or designee could report the findings to the Quality Assurance Committee and complete audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 830	Continued From page 11 (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive assessment nor develop care plan interventions for 1 of 3 residents (R125) reviewed for pressure ulcers which resulted in actual harm for this resident. The facility also failed to consistently monitor a pressure ulcer for 1 of 3 residents (R68) reviewed for pressure ulcers R125's Admission Record dated 8/16/16, identified R125 was admitted on 8/16/16. The admission Minimum Data Set (MDS) dated 8/23/16, identified R125 as being at risk for	2 900	These orders have been reviewed and will be corrected	1/10/17

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2 900	Continued From page 12	2 900		

pressure ulcers and identified three, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) pressure ulcers. The MDS also identified R125 as needing extensive assistance of two staff with bed mobility. The Care Area Assessment worksheet (CAA) identified pressure ulcers as a triggering condition, however, the CAA did not analyze the findings/trigger nor did it develop any care plan considerations related to pressure ulcers.

The Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance (tool used to determine appropriate repositioning needs) dated 8/16/16, identified R125 had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified was that both heels were "mushy."

Review of the physician orders for 8/16/16, identified wound care to coccyx open areas 2 times per week and PRN, cleanse with wound cleanser and apply foam adhesive dressing.

The Order Summary Report dated 8/17/16, identified wound care to open area on coccyx twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP) progress note dated 8/17/16, identified, "facility nurses reported that pt [patient] has a wound on

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2 900	Continued From page 13 her buttocks." The initial care plan dated 8/16/16, identified pressure ulcer with site being the coccyx related to edema. The care plan did not include any interventions to prevent worsening of the current pressure ulcers of the coccyx. The care plan did not identify any concerns with the heels. In addition, the record lacked evidence that the facility developed a comprehensive care plan during R125's stay at the facility. A hospice plan of care with a start date of 9/21/16, identified skin integrity-impaired (start date for this problem 8/11/16, 5 days before admission to the facility) secondary to mobility and nutritional deficit. Interventions identified assess actual/potential skin breakdown PRN starting 8/11/16, instruct on methods to prevent skin breakdown, RN instruct caregiver on methods to prevent skin breakdown. Wound care PRN starting 8/11/16. Hydrocolloid dressing to open area on coccyx, pressure relief cushion in wheelchair. The hospice care plan was not individualized and the facility did not develop a care plan individualized to R125's needs. The plan of care did not address the heels. Review of the weekly wound documentation on 8/16, 8/24, 8/31, 9/7, 9/13 and 9/14/16, identified pressure area to coccyx measuring 0.4 cm by 0.4 cm by 0.1 cm, stage 2. In addition, two other very small stage 2 pressure areas above one documented - these measure 0.2 cm x 0.2 cm. Treatment plan: wound care to coccyx open areas 2 times per week and as needed (PRN). Cleanse with wound cleaner and apply adhesive dressing. No other interventions were identified. The documentation identified the NP had been notified on 8/16/16 of the pressure ulcers.	2 900		

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2 900	Continued From page 14 The weekly wound documentation did not address "mushy" area to heels, nor any treatment/interventions. A hospice note from 9/8/16, identified coccyx area as being red, almost purple. Not opened. Dressing on right heel with left heel being red and not open. A hospice note dated 9/9/16, identified, "staff reports coccyx area is closed and purple." However, this is conflicting to the weekly wound documentation which does address healing of the pressure ulcers. A nursing note dated 9/8/16, identified that the wound team was asked to observe R125's coccyx area. The team observed a .7 cm by 1.1 cm skin tear to the left side over the PSIS (posterior superior iliac spine) with what appeared as a hematoma with purple bruising underneath at noon to 3 and at 5 o'clock. Redness measured 2.2 cm by 4.5 cm. The wound team felt that area was not related to pressure but more of friction on skin causing a skin tear. A nursing note on 9/13/16, indicated intact blister on right heel and that heels were mushy upon admission. Interventions to include, heel manager and dressing to heel. A follow up note on 9/13/16, indicated NP was there with resident. New order for coccyx wound. Order included left heel boggy, use heel manager and float, reposition every 2 hours, right heel has intact blister, left buttocks new order for dressing change. A 9/13/16, progress note from the nurse practitioner (NP) identified R125 was being seen for concerns of skin integrity issues per the facility nurse. A physical exam identified an intact blister noted on the right heel measuring 2.2 cm by 2 cm	2 900		

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2 900	Continued From page 15 and a 100% eschar (composed of necrotic granulation tissue, muscle, fat, tendon or skin) covered wound noted on the left buttocks 2.5 cm by 1 cm. as well as small clean open area noted on the coccyx measuring 0.2 cm by 0.2 cm. The assessment plan from the NP was as follows: 1. Pressure ulcer of heel, right stage 2: Patient had a foam dressing on right heel. When dressing removed an intact blister was noted on the heel. The facility nurse was unaware of this concern and unsure of when it was noted. Orders for wound care were cleanse with wound cleanser, pat dry, apply foam dressing, change on bath day and PRN if drainage or dislodgement. Heels to be floated while in bed and heel protectors on while up in wheelchair. 2. Pressure ulcer left buttock: Unstageable (tissue loss in which the base of the ulcer is completely covered by slough (tissue that is light colored soft and moist) and/or eschar (black or brown or dead tissue) in the wound bed. Upon examination a 100% eschar covered wound was noted on the left buttocks. The facility nurse was unaware of this sore and unsure of when this occurred. No dressing was noted on the sore. Orders for wound care were to cleanse with wound cleanser, pat dry, apply calcium alginate dressing and change on bath day and PRN for drainage and dislodgement, turn and reposition every 2 hours both while in bed an in wheelchair and pressure reduction mattress and cushion for wheelchair. 3. Pressure ulcer, coccyx, stage 2: This was a known pressure ulcer. The ulcer was noted to be clean with no signs of infection. The	2 900		

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2 900	Continued From page 16 wound was identified as having depth but unable to measure due to the small size of the wound. Orders included house barrier cream with zinc every shift and PRN, turn and reposition every 2 hours both while in bed and in wheelchair and pressure reduction mattress and cushion for wheelchair. The weekly wound documentation on 9/14/16, identified a weekly wound documentation and identified the following: - blister to the right heel first identified on 9/13/16. - stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0 to coccyx, and another to coccyx identified stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0, - pressure ulcer to left side of buttocks, 100% eschar - unstageable pressure ulcer (tissue loss in which the base of the ulcer is completely covered by slough, and/or eschar. R125 was seen by the physician on 9/16/16, and no changes were made to the treatment plan that was developed by the NP on 9/13/16. R125 passed away on 9/24/16. During interview on 11/30/16, at 12:35 p.m. registered nurse (RN)-B verified no care plan had been developed and interventions implemented to prevent the worsening of R125's pressure ulcers until 9/13/16. During interview on 12/1/16, at 1:35 p.m. the director of nursing (DON) stated there should have been interventions implemented upon admission and ongoing. He stated the first thing they should look at is the mattress, if it is the correct one for pressure areas as well as repositioning, cushions, nutritional interventions. DON stated the interventions should have been	2 900		

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2 900	Continued From page 17 looked at weekly to see if they were effective and updated as needed. He verified that R125's pressure ulcers worsened and interventions had not been implemented to prevent them from worsening. During interview on 12/12/16, at 2:30 p.m. the nurse practitioner (NP)-A stated R125 was admitted with a known stage 2 coccyx pressure ulcer. She stated that she did not visualize the stage 2 pressure ulcer on the day of admission, this was deferred. NP-A stated she did not know about R125's heels being mushy or about the other pressure ulcer on R125's buttocks. She stated that she was requested to look at R125 on 9/13/16, per the wound team. She stated at this time she observed a stage 2 pressure ulcer to the heel (it was a blister) and an unstageable ulcer to the buttocks as well as the stage 2 ulcer to the coccyx. She stated there was no dressing on the unstageable area and the heel had been covered with a dressing. She stated the facility nurse was unaware of both of these areas. She stated the 13th of September was the first she observed the areas, and verified the heel and buttocks had worsened. The facility policy Pressure Ulcer Treatment dated November 2016, identified the following protocol: Stage I protocol 1. Pressure: a. Determine cause of pressure and relieve; b. Redistribute pressure and interventions to off-load, if indicated; c. Implement pressure-relieving device(s) in accordance with resident's assessed needs; d. Evaluate until redness is no longer persistent;	2 900		

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2 900	Continued From page 18 e. Persistent redness is determined only after pressure has been relieved for at least 3/4 of the time it was applied and the redness remains (for example: if resident had been on side for two hours (120 minutes), reposition/off load area and re-evaluate site/area in 90 minutes to determine if area has resolved); f. Notify physician, family and appropriate facility personnel and document communication in medical record and g. Generate wound assessment and complete. h. Obtain new treatment order if indicated. 4. Immobility: a. Turn Schedule; and b. Restorative nursing (range of motion, walking, bed mobility). Evaluate and determine pain level with pain assessment. Stage II Protocol..... Follow-up If wound does not improve in 2-3 weeks, notify physician. Re-evaluate nutritional support, off-loading/redistribution devices and advanced wound product changes. R68's admission Minimum Data Set (MDS), dated 11/20/16, indicated no cognitive impairment and the presence of a Stage 1 pressure ulcer (area of unopened nonblanchable redness) on admission. R68's pressure ulcer Care Area Assessment (CAA), dated 11/23/16, identified a "nonblanchable redness to her R (right) buttock."	2 900		

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2 900	Continued From page 19 The CAA indicated R68's right buttock was being monitored daily for changes. Review of R68's facility "progress notes" indicated the following: - On 11/13/16, at 2:32 p.m. R68's admission documentation identified redness to the buttocks. Later that day, at 9:53 p.m. a scabbed area was noted on the right buttock measuring 1.5 cm (centimeters) x (by) 0.6 cm. - On 11/14/16, at 3:07 a.m. R68's buttocks was identified as "fragile but intact" indicating the facility's wound team would evaluate and treat the stage 1 pressure ulcer. - On 11/22/16, at 12:54 p.m. R68's right buttock was observed with a "superficial open area of maceration to wound edges." No measurements were documented. - On 11/24/16, at 11:28 a.m. R68's right buttock was observed with a small open area measuring 1 cm x 0.8 cm. The note did not describe the wound bed. - On 11/25/16, 11/26/16, and 11/27/16, R68's right buttock dressing was changed, however, the wound bed was not described. - On 11/30/16, at 3:13 p.m. R68's right buttocks dressing was changed and was "Noted to be improving," however, the wound measured 5.5 cm x 2.5 cm x 0.3 cm deep. The note classified the wound as "In between stage 1 and 2." R68's progress notes lacked daily monitoring of the pressure ulcer. R68's first Weekly Wound Documentation assessment, dated 11/28/16, indicated the pressure ulcer was first identified on 11/13/16. The assessment indicated R68's right buttock had increased to a stage 2 pressure ulcer measuring 2 cm x 1.5 cm x 0.3 cm deep with a	2 900		

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2 900	Continued From page 20 wound bed consisting of 75% (percent) granulation (healthy) tissue and 25% slough (necrotic tissue that doesn't promote healing). In addition, the assessment indicated R68 had developed a new stage 2 pressure ulcer on the left buttock measuring 1 cm x 0.5 cm x 0.2 cm deep consisting of 75% granulation tissue and 25% slough. Both assessments were inconsistent with R68's progress notes and the previous staging of R68's pressure ulcer. R68's temporary care plan, undated, directed to "Monitor pressure ulcer to R buttock daily" and "Document weekly on status of ulcer." It did not identify a pressure ulcer on the left buttock. During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-B changed R68's dressing to right buttock. After removing the soiled dressing, LPN-B stated R68's right buttock looked much better, the wound bed was superficial, consisting of healthy tissue, did not contain slough, and was surrounded by reddened peeling skin. LPN-B measured the pressure ulcer as 5.5 cm long x 2 cm wide. LPN-B was observed to measure the length from the open area of the ulcer on R68's lower buttock up to the area of intact reddened skin on the upper buttock (the periwound). LPN-B did not measure the length from open end to open end of the ulcer nor did she measure the depth of the ulcer during the observation. In addition, LPN-B observed R68's left buttock and stated the skin was healed and intact. During interview on 11/30/16, at 11:56 a.m. LPN-B stated the right buttock had an area in the middle (the pressure ulcer) that looked slightly deeper than the reddened superficial skin around it; however she "Put it all together" measuring it	2 900		

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2 900	Continued From page 21 all as one. During observation on 12/1/16, at 9:31 a.m. registered nurse (RN)-C performed wound cares and measured right buttock pressure ulcer 1.1 cm x 1.5 cm x 0.4 cm deep. RN-C stated the pressure ulcer was superficial and did not contain slough. In addition, RN-C stated the skin around the pressure was reddened, dry, and peeling, but would still be considered the periwound. RN-C stated R68's left buttock contained blanchable redness and was intact. During interview on 12/1/16, at 11:01 a.m. RN-C stated R68's pressure ulcer had been observed on 11/22/16 by the wound team when it had opened and progressed to a stage 2. RN-C stated the right buttocks was healing and the measurements for the previous day, on 11/30/16, were incorrect, further stating the wound bed should be measured separately from the periwound. RN-C stated R68 had never had a pressure ulcer on the left buttocks, further stating the wound assessment from 11/28/16 was incorrect. During interview on 12/1/16, at 11:47 a.m. RN-D stated the floor nurses were responsible for monitoring pressure ulcers daily and charting weekly with measurements. RN-D stated the daily monitoring should consist of the drainage, odors, how the wound bed looks, and if there are any changes. RN-D stated inconsistencies in measuring pressure ulcers was an ongoing issue. RN-D reported wound measurements, assessments, and monitoring needed to be accurate to ensure the right treatment is ordered and to prevent infections. A facility policy entitled Skin Care Protocol, dated	2 900		

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2 900	Continued From page 22 4/10, directed nurse managers or designee to "Document the assessment status weekly on the Weekly Wound Documentation" and specifically directed staff to perform daily monitoring of pressure ulcers, which included "Evaluation of the ulcer if no dressing present, evaluation of dressing, status of surrounding area, and presence of possible complications." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessing pressure ulcers and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (14) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by:	2 920		1/10/17

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2 920	Continued From page 23 Based on observation, interview and document review the facility failed to provide grooming cares for 3 of 5 residents (R202, R229, R44) who were unable to perform grooming and personal hygiene without extensive staff assistance. Findings include: R202's quarterly Minimum Data Set (MDS) dated 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in	2 920	These orders have been reviewed and will be corrected	

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2 920	Continued From page 24 the lounge area sitting with her daughter. R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on 11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this." During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands. During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing. During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed. During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.	2 920		

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2 920	Continued From page 25	2 920		

R229's admission MDS dated 8/29/16, included diagnoses of dementia and anxiety disorder. The MDS further indicated R229 had severe cognitive impairment, and required extensive assistance to complete personal hygiene. The Care Area Assessment (CAA) for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor.

R229's care plan, revised 11/23/16, identified R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning."

During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, an approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven.

During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. NA-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing, dressing, and brushing teeth, after which R229 returned to bed. R229 was not shaved, nor was offered assistance to shave, during the provision of cares. R229

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2 920	Continued From page 26 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven. During interview on 11/30/16, at 1:46 p.m. NA-D stated R229 was currently unshaven, and acknowledged R229 was not offered shaving that morning during his cares. NA-D stated,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed." During interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C stated she would expect and trust the nursing aides would at least offer to shave R229 every day, and further, that if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and R229 could be resistive to cares, but then stated "we should always, always" keep trying, and document refusals of care. During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) stated he would expect the nurses aides to follow their care guide and shave residents as needed. The DON also said he expected the nurses in charge to monitor staff to ensure routine cares were completed. R44's quarterly MDS dated 11/2/16, identified R44 had moderate cognitive impairment and required extensive assistance with personal hygiene. During observation on 11/28/16, at 3:02 p.m. R44 was seated in his wheelchair in the commons area. R44 had visibly long fingernails on all fingers of both his hands. R44 stated his nails	2 920		

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2 920	Continued From page 27 were, "Really too long," and he would like them trimmed shorter, but, "Not too many people" help him to do it. During subsequent observations on 11/29/16, at 1:18 p.m. and 11/30/16, at 1:45 p.m. R44 continued to have long fingernails on both of his hands. R44's care plan dated 11/26/16, identified R44 required extensive assistance from staff to complete grooming tasks adding, "I am scared when it comes to clipping my nails so I like it if you talk me through it and explain to me what you are doing." During interview on 11/30/16, at 1:51 p.m. NA-A stated R44 was not resistive with cares and nail care was typically completed on during his weekly bath. At 1:54 p.m. NA-A observed R44's fingernails and stated they were, "Very long," and should have been clipped because it was part of providing good hygiene and so he, "Can't scratch himself or others." During interview on 11/30/16, at 2:00 p.m. LPN-A stated she observed R44's fingernails and they were, "A little bit long," and the nurse assigned to him on his last bath day should have clipped them. R44's Treatment Administration Record dated 11/2016, identified an intervention, "Trim finger/toe nails weekly with bath and PRN [as needed]." The record identified trimming of nails had been completed two days prior to being observed with long fingernails by the surveyor on 11/26/16. A facility Resident Care: Grooming policy dated	2 920		

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	00261	A. BUILDING: _____ B. WING _____	12/01/2016

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2 920	Continued From page 28 1/2013, identified staff would, "...provide assist with grooming AM an PM according to resident needs." Further, the policy identified this included bathing, nail care, and shaving. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents personal preferences with activities of daily living are met. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was followed for 1 of 1 residents (R68) observed during wound cares. Findings include:	21385	These orders have been reviewed and will be corrected	1/10/17

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21385	Continued From page 29 R68's admission Minimum Data Set (MDS) dated 11/20/16, indicated the presence of a pressure ulcer (open wound related to pressure.) During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-placed a pair of gloves on her hands and did not wash her hands prior to donning. She then placed another pair of gloves over the already gloved hands. LPN-B removed R68's soiled dressing. After removing the soiled dressing, LPN-B stated it contained a small amount of serous (pale yellow color) drainage from R68's wound. LPN-B discarded the soiled dressing, washed, dried, and measured R68's wound then removed one of the two pairs of gloves. LPN-B proceeded to open the new dressing while wearing the second pair of potentially contaminated gloves and placed the new dressing over R68's wound. LPN-B stated her hands should have been washed immediately before donning gloves and would usually wash in between changing the dirty and clean dressings. LPN-B further stated it was her routine to double glove and not the facility's policy. During interview on 12/1/16, at 11:47 p.m. registered nurse (RN)-D stated gloves should be removed and changed in between dirty and clean dressings. RN-D further stated it was not the facility's policy to double glove and staff received education on proper hand hygiene during wound care in orientation and annually. During interview on 12/1/16, at 2:46 p.m. RN-E stated "The use of double gloving is not appropriate" and was not taught by the facility. RN-E further stated the observation provided an "Opportunity for re-education." The facility policy Infection Control: Use of Gloves	21385		

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21385	Continued From page 30 dated 1/05, directed staff to change gloves in between tasks on the same resident after Contact with material that may contain a high concentration of microorganisms. It further directed staff to remove gloves before touching non-contaminated items. The facility policy Infection Control: Hand Hygiene dated 2/10, directed staff to perform hand hygiene prior to application and upon removal of gloves. Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program. The DON or her designee could educate staff on policy and procedures and develop a monitoring system, to ensure compliance with proper hand hygiene. Time Period for Correction: Twenty-one (21) Days	21385		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a sanitary kitchen environment with dirty wall fans for 1 of 2 production kitchens which has the potential to effect 216 of 216 residents that receive meals from this kitchen.	21665	These orders have been reviewed and will be corrected	1/10/17

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21665	Continued From page 31 finding include: During observation of the residence kitchen on 11/28/16, at 10:32 a.m. two wall mounted fans were observed on and blowing in the dishwashing area. One mounted fan was observed blowing toward the clean side of the dish area where a three tier metal rolling cart stood. During observation, two racks of clean dishes, containing serving utensils and clear plastic jugs, came out of the dishwasher on a conveyor belt toward the fan. When turned off, the wire rings of the fan were covered with hanging thick gray fuzz extending from the middle to the back of the fan. During interview on 11/28/16, at 10:32 a.m. DM-A stated the thick gray substance "Looks like fuzz" and the fan "Needs to be cleaned." DM-A stated maintenance took apart the fans and cleaned them once a month but that one "Must've been missed." DM-A further stated the cleaned wet dishes were stored on the the metal cart in the afternoon to dry then put away at night. During observation on 12/1/16, at 10:14 a.m. the fan was observed cleaned without any gray fuzz. During interview on 12/1/16, at 10:19 a.m. DM-A stated that particular fan was different than the others and couldn't be taken apart to be cleaned. DM-A states "I wouldn't say it got missed, I'd say it only got half done," as staff had to climb up to clean the fan. DM-A further stated she would expect staff to remember that fan needs to be cleaned differently when completing the task. A facility policy entitled Cleaning of Wall Fans, undated, directed maintenance to remove the fan guards monthly; however, the policy directed the dietary staff to wipe off dust and dirt build up and	21665		

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21665	Continued From page 32 wash the fan guards. The policy further directed "Clean fans help prevent dust being moved onto food and food service equipment." A facility document entitled Completed Work Orders-Tasks indicated the fans had been serviced on 11/10/16. SUGGESTED METHOD OF CORRECTION: The Certified Dietary Manager (CDM) could review and revise the policies, educate kitchen staff for storing clean kitchen equipment. The CDM could conduct random audits to ensure a clean kitchen environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal grooming to promote dignity for 1 of 3 residents (R202) reviewed for activities of daily living and grooming. Findings include:	21805	These orders have been reviewed and will be corrected	1/10/17

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21805	Continued From page 33 R202's quarterly Minimum Data Set (MDS) dated 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in the lounge area sitting with her daughter. R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her	21805		

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21805	Continued From page 34	21805		

mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this."

During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands.

During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing.

During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed.

During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B she verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could train all staff on residents rights and monitor to ensure all residents are treated with dignity and respect. The DON or designee could report the findings to the Quality Assurance Committee and

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21805	Continued From page 35 complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28th 2016, through December 1st 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. An investigation of complaint H5518070 was completed and found not to be substantiated. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess a residents skin care needs for 1 of 3 records (R125) who was reviewed for pressure ulcers. Findings include: R125's admission Minimum Data Set (MDS) assessment dated 8/23/16, identified R125 as having three stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intactor open/ruptured blister)pressure ulcers that were present upon admission. The admission MDS assessment failed to include any Care Area Assessment (CAA) related to the identified skin issues/pressure ulcers. R125's medical record lacked any comprehensive assessment of R125's skin. A Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance dated 8/16/16, identified resident had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 pressure ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified both heels were "mushy". The Order Summary Report dated 8/17/16, indicated wound care to open area on coccyx	2 540		

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2 540	Continued From page 4 twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP) progress note dated 8/17/16, identified "facility nurses reported that pt [patient] has a wound on her buttocks that she will be evaluating once pt is laying back down in bed." During interview on 12/1/16, at 1:35 p.m. the director of nursing verified no comprehensive assessment had been completed and that the CAA should have been done. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		

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2 565	Continued From page 5 Based on observation, interview, and document review, the facility failed to implement the care plan for 1 of 5 residents (R229) reviewed for activities of daily living (ADLs), who was dependent upon staff for hygiene. Findings include: R229's diagnoses as indicated on the admission Minimum Data Set dated 8/29/16, included dementia and anxiety disorder. The Care Area Assessment for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor. R229's care plan, revised 11/23/16, identified R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning." During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven. During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. nursing assistant (NA)-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing,	2 565		

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2 565	Continued From page 6 dressing, and with brushing teeth, after which R229 returned to bed. R229 was not shaved, nor was he offered assistance to shave, during the provision of cares. R229 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven. During interview on 11/30/16, at 1:46 p.m. nursing assistant (NA)-D said R229 was currently unshaven, and acknowledged R229 was not offered shaving this morning during his cares. NA-D said,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed." During an interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C said she would expect and trust the aides would at least offer to shave R229 every day, and if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and that R229 could be resistive to cares. She also stated "we should always, always" keep trying, and document refusals of care. During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) said he would expect the aides to follow their care guide and shave residents as needed. The DON also stated he expected the nurses in charge to monitor staff to ensure routine cares were completed. A facility policy, Resident Assessment and Care Planning, dated Feb 2014, indicated as its purpose "To provide a means ...to assess residents, plan and implement an individualized care plan."	2 565		

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2 565	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R337) identified to be currently smoking while at the facility. Findings include:	2 830		

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2 830	Continued From page 8 R337's admission Minimum Data Set (MDS) dated 11/16/16, identified R337 had intact cognition. R337's Transitional Care Follow-Up Visit note dated 11/22/16, identified R337 was residing in the transitional care unit at the facility. The note identified several diagnoses which included, "Tobacco use disorder," with further dictation identifying, "Nursing staff report that patient sometimes goes out to smoke." During observation on 12/1/16, at 7:55 a.m. R337 was seated on her electric scooter coming up from the street to the main outside entrance to the facility. R337 was dressed in a light sweater and had no oxygen in place. When interviewed on 12/1/16, at 7:58 a.m. the receptionist (RCP)-A stated R337 goes outside to smoke and has to go down by, "Bass Lake Road," because she was not allowed to smoke on campus. R337's progress notes identified the following entries: - On 11/9/16, "...she [R337] refused to eat supper until she could go outside and have a cigarette." - On 11/10/16, "...spoke to resident about the risks of smoking and using butane lighter while using oxygen...made promise not to smoke." - On 11/16/16, "...resident able to wheel self and went outside..." - On 11/29/16, "...spoke with resident on this date regarding smoking outside on campus ... stated she [R337] is aware of this and that she is planning to take her electric scooter down to Bass Lake Road to smoke. Writer stated that we do not recommend she do that..."	2 830		

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2 830	Continued From page 9 R337's medical record was reviewed and lacked any identified comprehensive assessment to ensure R337 was safe to smoke without supervision, to determine if any interventions were required to ensure her safety with unsupervised smoking while off campus. R337's care plan dated 11/11/16, identified R337 was a smoker and, "Pt [patient] aware facility is non-smoking." The plan listed a goal for R337 to have decreased respiratory health complaints and listed interventions which included instructing R337 to have friends or family with her while smoking and to keep lighter in safe area away from oxygen tanks. During interview on 12/1/16, at 8:24 a.m. R337 stated she had been outside smoking that morning when the surveyor had observed her coming inside. She adding she goes out to smoke multiple times a day. R337 stated she goes, "Down by the street [Bass Lake Road]," to smoke. R337 stated she has her own lighter and cigarettes in the room, but no longer uses oxygen. R337 stated family will sometimes go with her if they are present, but she often goes by herself. Further, R337 stated she felt safe smoking on her own adding no staff had ever gone outside to observe her smoke or talked with her about her ability to smoke on her own. During interview on 12/1/16, at 8:59 a.m. nursing assistant (NA)-K stated R337 goes out to smoke several times during her shift by herself, "She don't tell us about it." NA-K stated she felt R337 was safe to smoke on her own because she could dress herself, "I think she can do it." During interview on 12/1/16, at 9:03 a.m.	2 830		

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2 830	Continued From page 10 registered nurse (RN)-F stated R337 goes outside on her own at times adding staff suspected she was smoking because she often smells like smoke when she comes back inside. RN-F stated R337 had a lighter when she admitted to the nursing home, however staff told her it was a non-smoking campus and it was removed. RN-F stated she was unaware if R337 had ever been assessed for her safety with unsupervised smoking, however, added it would be a good thing to do because R337, "Could burn herself" potentially if she was smoking and were to drop it or have a problem. During interview on 12/1/16, at 10:31 a.m. registered nurse (RN)-D stated R337 had been smoking while in the facility since her admission and being warned, "Several times" about smoking right outside the front doors and not signing herself out when she goes outside consistently. RN-D stated R337 had never been comprehensively assessed for safety with her smoking because it was a tobacco free campus, however, added R337 should have been assessed to ensure she was safe to smoke unsupervised because she could potentially start a fire or burn herself. Further, RN-D stated the facility did not have a smoking safety policy as it was, "In progress." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff and monitor to ensure all residents were assessed for safety related to smoking. The DON could educate all staff on these systems. The DON or designee could report the findings to the Quality Assurance Committee and complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 830		

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2 830	Continued From page 11 (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive assessment nor develop care plan interventions for 1 of 3 residents (R125) reviewed for pressure ulcers which resulted in actual harm for this resident. The facility also failed to consistently monitor a pressure ulcer for 1 of 3 residents (R68) reviewed for pressure ulcers R125's Admission Record dated 8/16/16, identified R125 was admitted on 8/16/16. The admission Minimum Data Set (MDS) dated 8/23/16, identified R125 as being at risk for	2 900		

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2 900	Continued From page 12	2 900		

pressure ulcers and identified three, stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) pressure ulcers. The MDS also identified R125 as needing extensive assistance of two staff with bed mobility. The Care Area Assessment worksheet (CAA) identified pressure ulcers as a triggering condition, however, the CAA did not analyze the findings/trigger nor did it develop any care plan considerations related to pressure ulcers.

The Braden Scale (assessment to identify pressure ulcer risk) dated 8/16/16, identified R125 as a moderate risk for pressure sores. A Tissue Tolerance (tool used to determine appropriate repositioning needs) dated 8/16/16, identified R125 had documented open areas on coccyx that were covered with foam dressings and the balance of buttock area skin was intact. The Admission Observations/Assessment dated 8/16/16, identified two stage 2 ulcers measuring 0.2 centimeters (cm) by 0.2 cm on the coccyx area and a 0.4 cm by 0.4 cm stage 2 area below the coccyx ulcers. The assessment also identified was that both heels were "mushy."

Review of the physician orders for 8/16/16, identified wound care to coccyx open areas 2 times per week and PRN, cleanse with wound cleanser and apply foam adhesive dressing.

The Order Summary Report dated 8/17/16, identified wound care to open area on coccyx twice a week and as needed (PRN). Cleanse with wound cleanser, apply foam adhesive dressing PRN. The nurse practitioner (NP) progress note dated 8/17/16, identified, "facility nurses reported that pt [patient] has a wound on

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2 900	Continued From page 13 her buttocks." The initial care plan dated 8/16/16, identified pressure ulcer with site being the coccyx related to edema. The care plan did not include any interventions to prevent worsening of the current pressure ulcers of the coccyx. The care plan did not identify any concerns with the heels. In addition, the record lacked evidence that the facility developed a comprehensive care plan during R125's stay at the facility. A hospice plan of care with a start date of 9/21/16, identified skin integrity-impaired (start date for this problem 8/11/16, 5 days before admission to the facility) secondary to mobility and nutritional deficit. Interventions identified assess actual/potential skin breakdown PRN starting 8/11/16, instruct on methods to prevent skin breakdown, RN instruct caregiver on methods to prevent skin breakdown. Wound care PRN starting 8/11/16. Hydrocolloid dressing to open area on coccyx, pressure relief cushion in wheelchair. The hospice care plan was not individualized and the facility did not develop a care plan individualized to R125's needs. The plan of care did not address the heels. Review of the weekly wound documentation on 8/16, 8/24, 8/31, 9/7, 9/13 and 9/14/16, identified pressure area to coccyx measuring 0.4 cm by 0.4 cm by 0.1 cm, stage 2. In addition, two other very small stage 2 pressure areas above one documented - these measure 0.2 cm x 0.2 cm. Treatment plan: wound care to coccyx open areas 2 times per week and as needed (PRN). Cleanse with wound cleaner and apply adhesive dressing. No other interventions were identified. The documentation identified the NP had been notified on 8/16/16 of the pressure ulcers.	2 900		

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2 900	Continued From page 14 The weekly wound documentation did not address "mushy" area to heels, nor any treatment/interventions. A hospice note from 9/8/16, identified coccyx area as being red, almost purple. Not opened. Dressing on right heel with left heel being red and not open. A hospice note dated 9/9/16, identified, "staff reports coccyx area is closed and purple." However, this is conflicting to the weekly wound documentation which does address healing of the pressure ulcers. A nursing note dated 9/8/16, identified that the wound team was asked to observe R125's coccyx area. The team observed a .7 cm by 1.1 cm skin tear to the left side over the PSIS (posterior superior iliac spine) with what appeared as a hematoma with purple bruising underneath at noon to 3 and at 5 o'clock. Redness measured 2.2 cm by 4.5 cm. The wound team felt that area was not related to pressure but more of friction on skin causing a skin tear. A nursing note on 9/13/16, indicated intact blister on right heel and that heels were mushy upon admission. Interventions to include, heel manager and dressing to heel. A follow up note on 9/13/16, indicated NP was there with resident. New order for coccyx wound. Order included left heel boggy, use heel manager and float, reposition every 2 hours, right heel has intact blister, left buttocks new order for dressing change. A 9/13/16, progress note from the nurse practitioner (NP) identified R125 was being seen for concerns of skin integrity issues per the facility nurse. A physical exam identified an intact blister noted on the right heel measuring 2.2 cm by 2 cm	2 900		

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2 900	Continued From page 15 and a 100% eschar (composed of necrotic granulation tissue, muscle, fat, tendon or skin) covered wound noted on the left buttocks 2.5 cm by 1 cm. as well as small clean open area noted on the coccyx measuring 0.2 cm by 0.2 cm. The assessment plan from the NP was as follows: 1. Pressure ulcer of heel, right stage 2: Patient had a foam dressing on right heel. When dressing removed an intact blister was noted on the heel. The facility nurse was unaware of this concern and unsure of when it was noted. Orders for wound care were cleanse with wound cleanser, pat dry, apply foam dressing, change on bath day and PRN if drainage or dislodgement. Heels to be floated while in bed and heel protectors on while up in wheelchair. 2. Pressure ulcer left buttock: Unstageable (tissue loss in which the base of the ulcer is completely covered by slough (tissue that is light colored soft and moist) and/or eschar (black or brown or dead tissue) in the wound bed. Upon examination a 100% eschar covered wound was noted on the left buttocks. The facility nurse was unaware of this sore and unsure of when this occurred. No dressing was noted on the sore. Orders for wound care were to cleanse with wound cleanser, pat dry, apply calcium alginate dressing and change on bath day and PRN for drainage and dislodgement, turn and reposition every 2 hours both while in bed an in wheelchair and pressure reduction mattress and cushion for wheelchair. 3. Pressure ulcer, coccyx, stage 2: This was a known pressure ulcer. The ulcer was noted to be clean with no signs of infection. The	2 900		

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2 900	Continued From page 16 wound was identified as having depth but unable to measure due to the small size of the wound. Orders included house barrier cream with zinc every shift and PRN, turn and reposition every 2 hours both while in bed and in wheelchair and pressure reduction mattress and cushion for wheelchair. The weekly wound documentation on 9/14/16, identified a weekly wound documentation and identified the following: - blister to the right heel first identified on 9/13/16. - stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0 to coccyx, and another to coccyx identified stage 2 pressure ulcer 0.2 cm by 0.2 cm by 0.0, - pressure ulcer to left side of buttocks, 100% eschar - unstageable pressure ulcer (tissue loss in which the base of the ulcer is completely covered by slough, and/or eschar. R125 was seen by the physician on 9/16/16, and no changes were made to the treatment plan that was developed by the NP on 9/13/16. R125 passed away on 9/24/16. During interview on 11/30/16, at 12:35 p.m. registered nurse (RN)-B verified no care plan had been developed and interventions implemented to prevent the worsening of R125's pressure ulcers until 9/13/16. During interview on 12/1/16, at 1:35 p.m. the director of nursing (DON) stated there should have been interventions implemented upon admission and ongoing. He stated the first thing they should look at is the mattress, if it is the correct one for pressure areas as well as repositioning, cushions, nutritional interventions. DON stated the interventions should have been	2 900		

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2 900	Continued From page 17 looked at weekly to see if they were effective and updated as needed. He verified that R125's pressure ulcers worsened and interventions had not been implemented to prevent them from worsening. During interview on 12/12/16, at 2:30 p.m. the nurse practitioner (NP)-A stated R125 was admitted with a known stage 2 coccyx pressure ulcer. She stated that she did not visualize the stage 2 pressure ulcer on the day of admission, this was deferred. NP-A stated she did not know about R125's heels being mushy or about the other pressure ulcer on R125's buttocks. She stated that she was requested to look at R125 on 9/13/16, per the wound team. She stated at this time she observed a stage 2 pressure ulcer to the heel (it was a blister) and an unstageable ulcer to the buttocks as well as the stage 2 ulcer to the coccyx. She stated there was no dressing on the unstageable area and the heel had been covered with a dressing. She stated the facility nurse was unaware of both of these areas. She stated the 13th of September was the first she observed the areas, and verified the heel and buttocks had worsened. The facility policy Pressure Ulcer Treatment dated November 2016, identified the following protocol: Stage I protocol 1. Pressure: a. Determine cause of pressure and relieve; b. Redistribute pressure and interventions to off-load, if indicated; c. Implement pressure-relieving device(s) in accordance with resident's assessed needs; d. Evaluate until redness is no longer persistent;	2 900		

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2 900	Continued From page 18 e. Persistent redness is determined only after pressure has been relieved for at least 3/4 of the time it was applied and the redness remains (for example: if resident had been on side for two hours (120 minutes), reposition/off load area and re-evaluate site/area in 90 minutes to determine if area has resolved); f. Notify physician, family and appropriate facility personnel and document communication in medical record and g. Generate wound assessment and complete. h. Obtain new treatment order if indicated. 4. Immobility: a. Turn Schedule; and b. Restorative nursing (range of motion, walking, bed mobility). Evaluate and determine pain level with pain assessment. Stage II Protocol..... Follow-up If wound does not improve in 2-3 weeks, notify physician. Re-evaluate nutritional support, off-loading/redistribution devices and advanced wound product changes. R68's admission Minimum Data Set (MDS), dated 11/20/16, indicated no cognitive impairment and the presence of a Stage 1 pressure ulcer (area of unopened nonblanchable redness) on admission. R68's pressure ulcer Care Area Assessment (CAA), dated 11/23/16, identified a "nonblanchable redness to her R (right) buttock."	2 900		

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2 900	Continued From page 19 The CAA indicated R68's right buttock was being monitored daily for changes. Review of R68's facility "progress notes" indicated the following: - On 11/13/16, at 2:32 p.m. R68's admission documentation identified redness to the buttocks. Later that day, at 9:53 p.m. a scabbed area was noted on the right buttock measuring 1.5 cm (centimeters) x (by) 0.6 cm. - On 11/14/16, at 3:07 a.m. R68's buttocks was identified as "fragile but intact" indicating the facility's wound team would evaluate and treat the stage 1 pressure ulcer. - On 11/22/16, at 12:54 p.m. R68's right buttock was observed with a "superficial open area of maceration to wound edges." No measurements were documented. - On 11/24/16, at 11:28 a.m. R68's right buttock was observed with a small open area measuring 1 cm x 0.8 cm. The note did not describe the wound bed. - On 11/25/16, 11/26/16, and 11/27/16, R68's right buttock dressing was changed, however, the wound bed was not described. - On 11/30/16, at 3:13 p.m. R68's right buttocks dressing was changed and was "Noted to be improving," however, the wound measured 5.5 cm x 2.5 cm x 0.3 cm deep. The note classified the wound as "In between stage 1 and 2." R68's progress notes lacked daily monitoring of the pressure ulcer. R68's first Weekly Wound Documentation assessment, dated 11/28/16, indicated the pressure ulcer was first identified on 11/13/16. The assessment indicated R68's right buttock had increased to a stage 2 pressure ulcer measuring 2 cm x 1.5 cm x 0.3 cm deep with a	2 900		

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2 900	Continued From page 20 wound bed consisting of 75% (percent) granulation (healthy) tissue and 25% slough (necrotic tissue that doesn't promote healing). In addition, the assessment indicated R68 had developed a new stage 2 pressure ulcer on the left buttock measuring 1 cm x 0.5 cm x 0.2 cm deep consisting of 75% granulation tissue and 25% slough. Both assessments were inconsistent with R68's progress notes and the previous staging of R68's pressure ulcer. R68's temporary care plan, undated, directed to "Monitor pressure ulcer to R buttock daily" and "Document weekly on status of ulcer." It did not identify a pressure ulcer on the left buttock. During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-B changed R68's dressing to right buttock. After removing the soiled dressing, LPN-B stated R68's right buttock looked much better, the wound bed was superficial, consisting of healthy tissue, did not contain slough, and was surrounded by reddened peeling skin. LPN-B measured the pressure ulcer as 5.5 cm long x 2 cm wide. LPN-B was observed to measure the length from the open area of the ulcer on R68's lower buttock up to the area of intact reddened skin on the upper buttock (the periwound). LPN-B did not measure the length from open end to open end of the ulcer nor did she measure the depth of the ulcer during the observation. In addition, LPN-B observed R68's left buttock and stated the skin was healed and intact. During interview on 11/30/16, at 11:56 a.m. LPN-B stated the right buttock had an area in the middle (the pressure ulcer) that looked slightly deeper than the reddened superficial skin around it; however she "Put it all together" measuring it	2 900		

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2 900	Continued From page 21 all as one. During observation on 12/1/16, at 9:31 a.m. registered nurse (RN)-C performed wound cares and measured right buttock pressure ulcer 1.1 cm x 1.5 cm x 0.4 cm deep. RN-C stated the pressure ulcer was superficial and did not contain slough. In addition, RN-C stated the skin around the pressure was reddened, dry, and peeling, but would still be considered the periwound. RN-C stated R68's left buttock contained blanchable redness and was intact. During interview on 12/1/16, at 11:01 a.m. RN-C stated R68's pressure ulcer had been observed on 11/22/16 by the wound team when it had opened and progressed to a stage 2. RN-C stated the right buttocks was healing and the measurements for the previous day, on 11/30/16, were incorrect, further stating the wound bed should be measured separately from the periwound. RN-C stated R68 had never had a pressure ulcer on the left buttocks, further stating the wound assessment from 11/28/16 was incorrect. During interview on 12/1/16, at 11:47 a.m. RN-D stated the floor nurses were responsible for monitoring pressure ulcers daily and charting weekly with measurements. RN-D stated the daily monitoring should consist of the drainage, odors, how the wound bed looks, and if there are any changes. RN-D stated inconsistencies in measuring pressure ulcers was an ongoing issue. RN-D reported wound measurements, assessments, and monitoring needed to be accurate to ensure the right treatment is ordered and to prevent infections. A facility policy entitled Skin Care Protocol, dated	2 900		

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2 900	Continued From page 22 4/10, directed nurse managers or designee to "Document the assessment status weekly on the Weekly Wound Documentation" and specifically directed staff to perform daily monitoring of pressure ulcers, which included "Evaluation of the ulcer if no dressing present, evaluation of dressing, status of surrounding area, and presence of possible complications." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessing pressure ulcers and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (14) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by:	2 920		

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2 920	Continued From page 23 Based on observation, interview and document review the facility failed to provide grooming cares for 3 of 5 residents (R202, R229, R44) who were unable to perform grooming and personal hygiene without extensive staff assistance. Findings include: R202's quarterly Minimum Data Set (MDS) dated 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in	2 920		

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2 920	Continued From page 24 the lounge area sitting with her daughter. R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on 11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this." During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands. During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing. During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed. During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.	2 920		

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2 920	Continued From page 25 R229's admission MDS dated 8/29/16, included diagnoses of dementia and anxiety disorder. The MDS further indicated R229 had severe cognitive impairment, and required extensive assistance to complete personal hygiene. The Care Area Assessment (CAA) for ADLs, dated 8/29/16, indicated R229 required assistance with all ADLs due to Lewy Body Dementia and Parkinsonian tremor. R229's care plan, revised 11/23/16, identified R229's abilities with grooming were variable, related to R229's diagnoses. The care plan directed: "I may be able to complete my shaving. Hand me my razor and give me cues to complete. I need you to stand on my left side and have my attention when you are giving me cues. If I am unable to complete, I need staff to shave me. I need to be shaved every morning." During observation on 11/28/16, at 3:45 p.m. R229 was ambulating in the dining room area on the first floor. R229 presented with facial hair, an approximately 1/8 inch growth, which also included longer stubbles under his chin. On 11/29/16, at 12:04 p.m. while seated at a table in the dining room for the noon meal, R229 remained unshaven. Later at 7:22 p.m., R229 was observed lying asleep in bed, with facial hairs still present and unshaven. During observation on 11/30/16, from 7:36 a.m. to 7:49 a.m. NA-D provided R229 with routine morning cares in his room. NA-D assisted R229 with toileting, washing, dressing, and brushing teeth, after which R229 returned to bed. R229 was not shaved, nor was offered assistance to shave, during the provision of cares. R229	2 920		

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2 920	Continued From page 26 remained in his room until NA-D assisted R229 to the dining room for breakfast at 9:12 a.m., still unshaven. During interview on 11/30/16, at 1:46 p.m. NA-D stated R229 was currently unshaven, and acknowledged R229 was not offered shaving that morning during his cares. NA-D stated,"I just forgot it." NA-D stated R229 was normally shaved every day. NA-D said R229 should be shaved everyday, "but [R229] just got missed." During interview on 11/30/16, at 2:04 p.m. licensed practical nurse (LPN)-C stated she would expect and trust the nursing aides would at least offer to shave R229 every day, and further, that if they were unsuccessful, to "let me know." LPN-C said R229 had behaviors and involuntary movements that interfered with completing ADLs, and R229 could be resistive to cares, but then stated "we should always, always" keep trying, and document refusals of care. During interview on 12/1/16, at 1:07 p.m. the director of nursing (DON) stated he would expect the nurses aides to follow their care guide and shave residents as needed. The DON also said he expected the nurses in charge to monitor staff to ensure routine cares were completed. R44's quarterly MDS dated 11/2/16, identified R44 had moderate cognitive impairment and required extensive assistance with personal hygiene. During observation on 11/28/16, at 3:02 p.m. R44 was seated in his wheelchair in the commons area. R44 had visibly long fingernails on all fingers of both his hands. R44 stated his nails	2 920		

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2 920	Continued From page 27 were, "Really too long," and he would like them trimmed shorter, but, "Not too many people" help him to do it. During subsequent observations on 11/29/16, at 1:18 p.m. and 11/30/16, at 1:45 p.m. R44 continued to have long fingernails on both of his hands. R44's care plan dated 11/26/16, identified R44 required extensive assistance from staff to complete grooming tasks adding, "I am scared when it comes to clipping my nails so I like it if you talk me through it and explain to me what you are doing." During interview on 11/30/16, at 1:51 p.m. NA-A stated R44 was not resistive with cares and nail care was typically completed on during his weekly bath. At 1:54 p.m. NA-A observed R44's fingernails and stated they were, "Very long," and should have been clipped because it was part of providing good hygiene and so he, "Can't scratch himself or others." During interview on 11/30/16, at 2:00 p.m. LPN-A stated she observed R44's fingernails and they were, "A little bit long," and the nurse assigned to him on his last bath day should have clipped them. R44's Treatment Administration Record dated 11/2016, identified an intervention, "Trim finger/toe nails weekly with bath and PRN [as needed]." The record identified trimming of nails had been completed two days prior to being observed with long fingernails by the surveyor on 11/26/16. A facility Resident Care: Grooming policy dated	2 920		

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2 920	Continued From page 28 1/2013, identified staff would, "...provide assist with grooming AM an PM according to resident needs." Further, the policy identified this included bathing, nail care, and shaving. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents personal preferences with activities of daily living are met. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was followed for 1 of 1 residents (R68) observed during wound cares. Findings include:	21385		

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21385	Continued From page 29 R68's admission Minimum Data Set (MDS) dated 11/20/16, indicated the presence of a pressure ulcer (open wound related to pressure.) During observation on 11/30/16, at 9:40 a.m. licensed practical nurse (LPN)-placed a pair of gloves on her hands and did not wash her hands prior to donning. She then placed another pair of gloves over the already gloved hands. LPN-B removed R68's soiled dressing. After removing the soiled dressing, LPN-B stated it contained a small amount of serous (pale yellow color) drainage from R68's wound. LPN-B discarded the soiled dressing, washed, dried, and measured R68's wound then removed one of the two pairs of gloves. LPN-B proceeded to open the new dressing while wearing the second pair of potentially contaminated gloves and placed the new dressing over R68's wound. LPN-B stated her hands should have been washed immediately before donning gloves and would usually wash in between changing the dirty and clean dressings. LPN-B further stated it was her routine to double glove and not the facility's policy. During interview on 12/1/16, at 11:47 p.m. registered nurse (RN)-D stated gloves should be removed and changed in between dirty and clean dressings. RN-D further stated it was not the facility's policy to double glove and staff received education on proper hand hygiene during wound care in orientation and annually. During interview on 12/1/16, at 2:46 p.m. RN-E stated "The use of double gloving is not appropriate" and was not taught by the facility. RN-E further stated the observation provided an "Opportunity for re-education." The facility policy Infection Control: Use of Gloves	21385		

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21385	Continued From page 30 dated 1/05, directed staff to change gloves in between tasks on the same resident after Contact with material that may contain a high concentration of microorganisms. It further directed staff to remove gloves before touching non-contaminated items. The facility policy Infection Control: Hand Hygiene dated 2/10, directed staff to perform hand hygiene prior to application and upon removal of gloves. Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program. The DON or her designee could educate staff on policy and procedures and develop a monitoring system, to ensure compliance with proper hand hygiene. Time Period for Correction: Twenty-one (21) Days	21385		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a sanitary kitchen environment with dirty wall fans for 1 of 2 production kitchens which has the potential to effect 216 of 216 residents that receive meals from this kitchen.	21665		

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21665	Continued From page 31 finding include: During observation of the residence kitchen on 11/28/16, at 10:32 a.m. two wall mounted fans were observed on and blowing in the dishwashing area. One mounted fan was observed blowing toward the clean side of the dish area where a three tier metal rolling cart stood. During observation, two racks of clean dishes, containing serving utensils and clear plastic jugs, came out of the dishwasher on a conveyor belt toward the fan. When turned off, the wire rings of the fan were covered with hanging thick gray fuzz extending from the middle to the back of the fan. During interview on 11/28/16, at 10:32 a.m. DM-A stated the thick gray substance "Looks like fuzz" and the fan "Needs to be cleaned." DM-A stated maintenance took apart the fans and cleaned them once a month but that one "Must've been missed." DM-A further stated the cleaned wet dishes were stored on the the metal cart in the afternoon to dry then put away at night. During observation on 12/1/16, at 10:14 a.m. the fan was observed cleaned without any gray fuzz. During interview on 12/1/16, at 10:19 a.m. DM-A stated that particular fan was different than the others and couldn't be taken apart to be cleaned. DM-A states "I wouldn't say it got missed, I'd say it only got half done," as staff had to climb up to clean the fan. DM-A further stated she would expect staff to remember that fan needs to be cleaned differently when completing the task. A facility policy entitled Cleaning of Wall Fans, undated, directed maintenance to remove the fan guards monthly; however, the policy directed the dietary staff to wipe off dust and dirt build up and	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	12/01/2016

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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21665	Continued From page 32 wash the fan guards. The policy further directed "Clean fans help prevent dust being moved onto food and food service equipment." A facility document entitled Completed Work Orders-Tasks indicated the fans had been serviced on 11/10/16. SUGGESTED METHOD OF CORRECTION: The Certified Dietary Manager (CDM) could review and revise the policies, educate kitchen staff for storing clean kitchen equipment. The CDM could conduct random audits to ensure a clean kitchen environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide personal grooming to promote dignity for 1 of 3 residents (R202) reviewed for activities of daily living and grooming. Findings include:	21805		

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21805	Continued From page 33 R202's quarterly Minimum Data Set (MDS) dated 11/8/16, identified R202 had moderate impaired cognition. The MDS indicated R202 required extensive assistance of staff with grooming. R202's care plan, last revised for grooming/hygiene on 6/21/16, identified that R202 needed assist with grooming/hygiene related to conditions including impaired cognition and decreased mobility. The care plan further identified R202 had dementia/memory loss. During initial observation in the lounge area on 11/29/16, at 1:16 p.m. R202 was observed to have long facial hair on her chin and upper lip. The facial hair was easy to visualize during conversation. R202 was also observed to have long, jagged fingernails that had black and brown debris under the nails. During observation on 11/29/16, at 6:45 p.m. R202 was observed lying in bed after evening cares had been completed. R202 still had long facial hair and dirty long nails. During observation on 11/30/16, at 8:16 a.m. R202 was observed in the dining room. Nails remained very dirty underneath and also had a brown substance noted on top of several nails and the facial hair remained. On 11/30/16, at 1:11 p.m. R 202 was observed in the lounge area sitting with her daughter. R202 continued to have long facial hair and long nails with dark brown and black debris underneath. During interview on11/30/16, at 1:11 p.m. R202's family member (F)-A stated she had expressed concern to the facility previously about her	21805		

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21805	Continued From page 34	21805		

mother's appearance. She stated on previous occasions she had noted bowel movement (BM) on her mother's hands and under her nails. She also stated that her mother having long facial hair and dirty long fingernails had been addressed with the facility but it continued to be a common occurrence. The daughter became weepy and stated, "My mother was a very classy lady and she would be appalled by this."

During observation on 12/1/16, at 9:26 a.m. R202 continued to have long facial hair and black/brown substance under nails. A sour odor was noted to be coming from R202's hands.

During interview on 12/1/16, at 9:44 a.m. nursing assistant (NA)-B stated residents are shaved with cares if needed and nails are done with bathing.

During interview on 12/1/16, at 9:50 a.m. NA-C stated residents get shaved with their cares if needed and get nails done with baths and as needed.

During interview on 12/1/16, at 12:55 p.m. registered nurse (RN)-B she verified the presence of long facial hair on R202. She stated R202 should have been shaved with cares. She also stated that nails are normally done with baths but should also be done as needed. She verified R202's nails were long and dirty and should have been cleaned and trimmed with cares.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could train all staff on residents rights and monitor to ensure all residents are treated with dignity and respect. The DON or designee could report the findings to the Quality Assurance Committee and

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21805	Continued From page 35 complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		