CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZLT2

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLETED BY THE ST	TATE SURVEY AGENCY Facility ID: 00261	
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	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ES	13 PTIP 22 CLIA 7. On-Site Visit 9. Other	
6. DATE OF SURVEY 02/01/2017 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICl 04 SNF 08 OPT/SP 12 RF	FISCAL YEAR ENDING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 258 (L18) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 258 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S	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: ICF IID (L42) (L43) HOW LTC CANCELLATION DATE):	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size X 5. Life Safety Code 9. Beds/Room * Code: A*,5 (L12) 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
Facility's request for a continuing waiver involving K351 17. SURVEYOR SIGNATURE LoAnn DeGagne, HFE NE	Date : 02/01/2017 (L1		L20)
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	BE COMPLETED BY HCFA REGION 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) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIVE A. Suspension of	DATE ENDING DATE (L25) E SANCTIONS	26. TERMINATION ACTION: (L30) VOLUNTARY 00 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change	
(L27) B. Rescind Susp	(L44) pension Date: (L45)	00-Active	
28. TERMINATION DATE: 29.	INTERMEDIARY/CARRIER NO. 03001 (L3	30. REMARKS	
31. RO RECEIPT OF CMS-1539 32. (L32)	DETERMINATION OF APPROVAL DATE 01/26/2017 (L3:	DETERMINATION APPROVAL	



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.

St Therese Home February 17, 2017 Page 2

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



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.

St Therese Home February 17, 2017 Page 2

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

		POST	-CERT	TFICATIO	N REVISIT RI	EPORT	•		
PROVIDE	R / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION					DATE OF F	REVISIT
IDENTIFIC 245518	CATION NUMBER	A. Building B. Wing					Y2	2/1/2017	Y3
NAME OF	FACILITY				STREET ADDRESS, CIT	Y, STATE, ZII	P CODE	•	
ST THER	RESE HOME				8000 BASS LAKE ROAD)			
	NEW HOPE, MN 55428								
provision					ry should be fully identifie 3-2567 (prefix codes show	•	•		
ITEI	М	DATE	ITEM		DATE	ITEM		1	DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0241	Correction	ID Prefix	F0272	Correction	ID Prefix	F0282	C	orrection
Reg.#	483.15(a)	Completed	Reg. #	483.20(b)(1)	Completed	Reg. #	483.20(k)(3)(ii)	C	ompleted
		04/40/0047	1.00		04/40/0047	1.00		0	4/40/0047



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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REVISI	IT
00261	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			

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).

ITEI	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20540		Correction	ID Prefix	20565		Correction	ID Prefix	20830		Correction
Reg. #	MN Rule 4658.04 Subp. 1 & 2	100	Completed	Reg. #	MN Rule Subp. 3	e 4658.0405	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 4658.05 Subp. 3	525	Completed	Reg.#	MN Rule Subp. 6	e 4658.0525 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 4658.14	100	Completed	Reg. #	MN St. Subd. 5	Statute 144.651	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			
REVIEWE	D BY	REVIEWE	D BY	DATE		SIGNATURE OF SU	JRVEYOR			DATE	
STATE AG	SENCY	(INITIALS	KL/KJ	02/17/	2017		3	7040		02/0	1/2017
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
FOLLOWU 12/1/2010	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE ED DEFICIENCIES				YE	s 🔲 no
				<u> </u>		Page 1 of 1			EVENT ID:	7I T212	

Page 1 of 1 EVENT ID: ZLT212

STATE FORM: REVISIT REPORT

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZLT2

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	Fa	acility ID: 00261
MEDICARE/MEDICAID PROVIDER NO. (L1) 245518 2.STATE VENDOR OR MEDICAID NO. (L2) 712242000		3. NAME AND ADD (L3) ST THERES (L4) 8000 BASS L (L5) NEW HOPE,	E HOME AKE ROAD	ТΥ	(I	L6) 55428	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNE (L9)	RSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other nplaint
6. DATE OF SURVEY 12/01/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	Е	FISCAL YEAR ENDING I	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 258 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS Facility's request for a 17. SURVEYOR SIGNATURE		X B. Not in Com Requirements a ICF (L42)	nce With quirements Based On: .cceptable POC pliance with Program and/or Applied Waiv IID (L43) AATION DATE):	ers:	2 2 3. : - 4 5. : * Code: 15. FACILIT 1861 (e) (1	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	9. Beds/Room (L12) (L15)	or
Jennifer Bahr,	HFE NE I	<u> </u>	12/27/2016	(L19)	Kate J	ohnsTon, Pro	ogram Specialis	01/23/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY	pate (L21)		IPLIANCE WITH C	IVIL			al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24)	23. LTC AGREEMI BEGINNING I (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTAR 01-Merger, C			et Health/Safety
	27. ALTERNATIVI A. Suspension of B. Rescind Suspension of the susp	of Admissions:	(L44)			voluntary Termination son for Withdrawal	OTHER 07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	(L45) ARRIER NO.	(L31)	•	V K521 Emailed	l to ROCHI 01/31/2	2017 Co.
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (OF APPROVAL DAT	TE (L33)		red 01/26/2017		



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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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

St. Therese Home December 15, 2016 Page 4

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

St. Therese Home December 15, 2016 Page 5

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 St. Therese Home December 15, 2016 Page 6

> 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

PRINTED: 12/27/2016 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245518	B. WING _		12/01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 000	as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electronic be used as verificated. An investigation of completed and four Upon receipt of an an on-site revisit of your validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an elenhances each resignal recognition of his This REQUIREMENTS. This REQUIREMENTS.	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 ic submission of the POC will ion of compliance. Complaint H5518070 was not not to be substantiated. Cacceptable electronic POC, an air facility may be conducted to notial compliance with the en attained in accordance with an attained in accordance with the compliance or ident's dignity and respect in sor her individuality. Note that the conducted ion, interview, and document	F 00	Persons responsible: Clinical	1/10/17
	grooming to promot (R202) reviewed for grooming.	ailed to provide personal te dignity for 1 of 3 residents r activities of daily living and		It is the policy of St. Therese to procare for residents in a manner and environment that maintains or enhanced	omote I in an ances
	Findings include: R202's quarterly Mi	nimum Data Set (MDS) dated		each resident's dignity and respect recognition of his or her individualit Resident Care: Grooming" policy a	ty. "The

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.

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	` COMPLETED	
		245518	B. WING _		12/	01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241	11/8/16, identified F cognition. The MDS extensive assistant R202's care plan, la grooming/hygiene oneeded assist with conditions including decreased mobility identified R202 had During initial observations and the facial hair was conversation. R202 long, jagged finger debris under the natural During observation R202 was observed cares had been confacial hair and dirty During observation R202 was observed cares had been confacial hair and dirty During observation R202 was observed remained very dirty brown substance not and the facial hair of 11/30/16, at 1:1 the lounge area sitt R202 continued to nails with dark brown underneath. During interview on family member (F)-	R202 had moderate impaired indicated R202 required se of staff with grooming. Rast revised for on 6/21/16, identified that R202 grooming/hygiene related to gimpaired cognition and The care plan further dementia/memory loss. Vation in the lounge area on m. R202 was observed to r on her chin and upper lip. easy to visualize during was also observed to have hails that had black and brown hils. On 11/29/16, at 6:45 p.m. delying in bed after evening mpleted. R202 still had long long nails. On 11/30/16, at 8:16 a.m. de in the dining room. Nails underneath and also had a oted on top of several nails emained. 1 p.m. R 202 was observed in ing with her daughter. have long facial hair and long	F 24	NA/R Care Audit were review updated by ADON of Indirect audit was updated to specific facial hair grooming. To assure continued complia following plan has been impled 1. R202 was appropriately gr 12/1/16 on the PM shift. Utiliz Care Audit to assess cares for on the AM shift and once on on 12/23/16. Per the results Audit, education on appropriate grooming will be provided as 2. Use NA/R Care Audit for a audits to ensure that grooming specifically facial hair and nat being completed. Beginning there will be 6 audits per unit performed for the duration of Any corrective action will be it addressed with staff while at in private with the staff member necessary, until compliance it as determined by the QI/QA and their recommendations. 3. Reeducating nursing staff direct patient care on "Reside Grooming" policy beginning of Licensed staff will continue to weekly skin assessment on eresident's bath day which will assessing nail care, facial had overall grooming. Re-education completion of skin assessment 12/22/16.	care. The cally add nce, the emented: comed on the NA/R or R202 once the PM shift of the Care the resident needed. Tandoming, il care, is 12/23/16, per week to one month. Immediately the POC, or oer, if is achieved committee Tinvolved in the total care: In 12/23/16. To complete a each to include the total control on upon	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 241	occasions she had on her mother's har also stated that her and dirty long finger with the facility but i occurrence. The da stated, "My mother she would be appal During observation continued to have leblack/brown substawas noted to be con During interview on assistant (NA)-B stacares if needed and get naineeded. During interview on stated residents geneeded and get naineeded. During interview on registered nurse (R presence of long fa R202 should have be	ce. She stated on previous noted bowel movement (BM) and under her nails. She mother having long facial hair rnails had been addressed toontinued to be a common ughter became weepy and was a very classy lady and led by this." on 12/1/16, at 9:26 a.m. R202 ong facial hair and nce under nails. A sour odor ming from R202's hands. 12/1/16, at 9:44 a.m. nursing ated residents are shaved with a nails are done with bathing. 12/1/16, at 9:50 a.m. NA-C t shaved with their cares if lis done with baths and as 12/1/16, at 12:55 p.m. N)-B she verified the cial hair on R202. She stated been shaved with cares. She	F 2-	4. The results of the random NA Audits will be reported to the QI/committee. Revisions made per committee recommendations. Fassessment will continue to be outpon admission for an initial che	QA QI/QA ull skin ompleted	
F 272 SS=D	baths but should als verified R202's nails should have been of cares. 483.20(b)(1) COMF	s are normally done with so be done as needed. She s were long and dirty and eleaned and trimmed with PREHENSIVE	F 2	72		1/10/17
		nduct initially and periodically accurate, standardized				

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F 272	functional capacity. A facility must make assessment of a refrested assessment by the State. The aleast the following: Identification and doustomary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-keychosocial well-keychosocial well-keychosocial functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of state additional assessments areas triggered by Data Set (MDS); ar Documentation of procumentation	e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; r patterns; peing; g and structural problems; and health conditions; all status; and procedures; l; summary information regarding ssment performed on the care the completion of the Minimum and participation in assessment.	F 272			
	by:	NT is not met as evidenced vand document review the		Persons responsible: RAI Coordi	nators.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 272	residents skin care (R125) who was re (R125) who was re Findings include: R125's admission I assessment dated having three stage dermis presenting a red-pink wound be present as an intact blister) pressure uld admission. The adfailed to include an (CAA) related to the issues/pressure uld R125's medical red assessment of R12 (assessment to ide	Minimum Data Set (MDS) 8/23/16, identified R125 as 2 (partial thickness loss of as a shallow open ulcer with a d without slough. May also tor open/ruptured ters that were present upon lmission MDS assessment by Care Area Assessment e identified skin	F 272	DEFICIENCY)	mplete ment to inary an, eir pasis. mal dent dicy N of	
	pressure sores. A 8/16/16, identified rareas on coccyx the dressings and the lawas intact. The Ad Observations/Asse identified two stage 0.2 centimeters (charea and a 0.4 cm the coccyx ulcers. both heels were "multiple of the Corder Summa indicated wound cat wice a week and a with wound cleanse."	Tissue Tolerance dated resident had documented open at were covered with foam balance of buttock area skin mission ssment dated 8/16/16, a 2 pressure ulcers measuring m) by 0.2 cm on the coccyx by 0.4 cm stage 2 area below The assessment also identified		Observation Assessment on all resignation admission. A review of all curresidents will be completed to ensure residents have a completed Admiss Observation Assessment on 12/23/2 Any corrective action will be address with staff as necessary. 3. Further education for all licensed on the Admission Observation Assessment process will be completed 1/9/17. Clinical Coordinators and R Coordinators have had additional education on completing Care Area Assessments (CAAs)on 12/22/16. Attendance was taken and those not attendance will complete education to next scheduled shift.	dents ent re all ion 16. sed d staff eted by Al	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282 SS=D	progress note dated nurses reported that her buttocks that she laying back down in During interview on director of nursing vassessment had be CAA should have be 483.20(k)(3)(ii) SEP PERSONS/PER CAT The services provided by the services provided b	d 8/17/16, identified "facility t pt [patient] has a wound on the will be evaluating once pt is bed." 12/1/16, at 1:35 p.m. the rerified no comprehensive en completed and that the een done.	F 28	4. A peand Clir 12/28/10 per CMS complet reported recommeach un and/or un determing their recommendations	er audit between RAI Coordinators starting 6 to ensure CAAs are suffices of sequest. Random audits were detected to ensure compliance and to the QI/QA committee for the per week for a period of suntil compliance is achieved and by the QI/QA committee commendations.	cient as will be nd or their lits on 30 days	1/10/17
	by: Based on observat review, the facility fa plan for 1 of 5 resid activities of daily livi dependent upon sta Findings include: R229's diagnoses a Minimum Data Set dementia and anxie Assessment for AD R229 required assis Lewy Body Dement	ion, interview, and document ailed to implement the care ents (R229) reviewed for ng (ADLs), who was aff for hygiene. Is indicated on the admission dated 8/29/16, included the dated 8/29/16, included the dated 8/29/16, indicated stance with all ADLs due to ia and Parkinsonian tremor.		It is the the Adm provide team to impleme and eva care and This provident function Observa Groomin	as responsible: Clinical nators, DON, and/or designed policy of St. Therese to complission Observation Assess a means for the interdisciple assess residents, plan and ent an individualized care paluate the effectiveness of the direatment on an ongoing to be completed to achieve/maintain an optical level. The Admission ation Assessment, "Residering" policy and NA/R Care Aviewed by ADON of Indirections.	mplete ment to linary I lan, heir basis. I timal	

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F 282	R229's abilities with related to R229's didirected: "I may be Hand me my razor complete. I need y have my attention will am unable to come. I need to be signatured by have my attention will am unable to come. I need to be signatured by was ambulating the first floor. R229 was ambulating the first floor. R229 approximately 1/8 included longer stured to line was observed lying still present and unshaver and active sing, and with R229 with routine in NA-D assisted R22 dressing, and with R229 returned to be was he offered ass provision of cares. until NA-D assisted breakfast at 9:12 a. During interview on assistant (NA)-D said, "I just fo was normally shave	agrooming were variable, agnoses. The care plan e able to complete my shaving, and give me cues to ou to stand on my left side and when you are giving me cues. mplete, I need staff to shave naved every morning." on 11/28/16, at 3:45 p.m. ng in the dining room area on presented with facial hair, nch growth, which also obles under his chin. On o.m. while seated at a table in the noon meal, R229 asleep in bed, with facial hairs shaven. on 11/30/16, from 7:36 a.m. to ssistant (NA)-D provided norning cares in his room. 9 with toileting, washing, orushing teeth, after which ed. R229 was not shaved, nor istance to shave, during the R229 remained in his room. R229 to the dining room for	F 282	on 12/19/16. NA/R Care Audit was updated to specifically add facial grooming. 1. Facial grooming was completed R229 on 11/30/16 during HS care Utilize the NA/R Care Audit to asscares for R229 once on the AM is once on the PM shift on 12/22/16 results of the Care Audit, educating appropriate resident grooming with provided at point of care. 2. Use NA/R Care Audit for rand audits to ensure that grooming, specifically facial hair and nail cabeing completed. Six audits per week for one month will be conducted until compliance is achieved as determined by the QI/QA committed their recommendations. 3. Reeducating nursing staff involved involved in their recommendations. 3. Reeducating nursing staff involved in their recommendations. 3. Reeducating nursing staff involved in their recommendations. 3. Reeducating nursing staff involved in their recommendations. 4. Ticensed staff will continuate to be completed in the complete of skin assessment in the complete in the recommendations. For a seessment will continue to be completed in the complete in the complete in the recommendations. For a seessment will continue to be completed in the complete in the recommendations. For a seessment will continue to be completed in the complete in the recommendations. For a seessment will continue to be completed in the complete in the recommendations. For a seessment will continue to be completed in the complete in	hair ed to es. seess hift and . Per the on on ell be om re, is unit per ucted or the and ell be end on ell include ell includ	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	licensed practical nexpect and trust the shave R229 every ounsuccessful, to "le R229 had behavior that interfered with R229 could be resis "we should always, document refusals During interview on director of nursing (the aides to follow to residents as needed expected the nurse ensure routine care. A facility policy, Resplanning, dated Felpurpose "To provide residents, plan and care plan." 483.25(a)(3) ADL C	on 11/30/16, at 2:04 p.m. urse (LPN)-C said she would a aides would at least offer to day, and if they were and involuntary movements completing ADLs, and that stive to cares. She also stated always" keep trying, and of care. 12/1/16, at 1:07 p.m. the (DON) said he would expect their care guide and shave d. The DON also stated he in charge to monitor staff to be were completed. Sident Assessment and Care to 2014, indicated as its le a meansto assess implement an individualized care provided to the care provided and shave a meansto assess implement an individualized care provided to the care provided as its least provided to a meansto assess implement an individualized care provided to the care provid	F 282			1/10/17
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal				
	by: Based on observat	NT is not met as evidenced tion, interview and document ailed to provide grooming cares		Persons responsible: Clinical Coordinators, DON, and/or designe	9 e	

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F 312	for 3 of 5 residents unable to perform on hygiene without existed in the second of the	(R202, R229, R44) who were grooming and personal tensive staff assistance. inimum Data Set (MDS) dated R202 had moderate impaired indicated R202 required the of staff with grooming. ast revised for on 6/21/16, identified that R202 grooming/hygiene related to grimpaired cognition and. The care plan further dementia/memory loss. vation in the lounge area on m. R202 was observed to ir on her chin and upper lip. easy to visualize during was also observed to have nails that had black and brown ails. on 11/29/16, at 6:45 p.m. delying in bed after evening mpleted. R202 still had long along nails. on 11/30/16, at 8:16 a.m. delying in the dining room. Nails a underneath and also had a oted on top of several nails	F 31	It is the policy of St. Therese th NA/R will care for each resident indicated on the care plan and Assignment Sheet. A review of Care Audit and "Resident Care Grooming", "Infection Control: I Hygiene" and "NA/R Care Obse Completion" policies on 12/19/ADON of Indirect Care. 1. Facial grooming was completed the Cares on 11/30/16 for R229 grooming for R202 was completed to R44 on 12/1/16 on Utilize the NA/R Care Audit to a cares for R202, R229, and R44 the AM shift and once on the P12/22/16 and 12/23/16. Per the the Care Audit, education on a resident grooming will be provious needed and any corrective actifollow if necessary. 2. Use NA/R Care Audit for rare audits to ensure that grooming specifically facial hair and nail obeing completed. Six audits peweek starting on 12/23/16 for or and/or until compliance is achied determined by the QI/QA commitheir recommendations. 3. Reeducating nursing staff in direct patient care on "Residen Grooming" and "Infection Contil Hygiene" policies starting on 12 Licensed staff will continue to contil the continue to the	t as If the NA/R Hand ervation If by the Ited during Facial eted on was PM shift. Assess Fonce on M shift on Iterested as Iterested	

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F 312	R202 continued to nails with dark browunderneath. During interview on family member (F)-concern to the facil mother's appearance occasions she had on her mother's ha also stated that her and dirty long finge with the facility but occurrence. The dastated, "My mother she would be appa. During observation continued to have I black/brown substawas noted to be concurrenced in the black/brown substawas noted to be concurrenced in the concurrence on the concurrence of	have long facial hair and long on and black debris 11/30/16, at 1:11 p.m. R202's A stated she had expressed ity previously about her ce. She stated on previous noted bowel movement (BM) and under her nails. She mother having long facial hair rnails had been addressed it continued to be a common aughter became weepy and was a very classy lady and led by this." on 12/1/16, at 9:26 a.m. R202 ong facial hair and ance under nails. A sour odor ming from R202's hands. 12/1/16, at 9:44 a.m. nursing ated residents are shaved with d nails are done with bathing. 12/1/16, at 9:50 a.m. NA-C t shaved with their cares if its done with baths and as 12/1/16, at 12:55 p.m. its done with baths and as 12/1/16, at 12:55 p.m. its done with baths but should eded. She verified R202's I dirty and should have been	F 312	weekly skin assessment on each resident's bath day which will incl assessing nail care, facial hair, at overall grooming. Re-education of completion of skin assessment st 12/22/16. Re-educating licensed on hand washing procedure start 12/23/16. 4. The results of the random NA Audits will be reported to the QI/O committee. Revisions made per committee recommendations. Further assessment will continue to be componed admission for an initial check.	ude nd n carted on nurses ing on (R Care QA QI/QA ull skin ompleted	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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F 312	Continued From pa	ige 10	F 31	2		
	diagnoses of deme MDS further indicat impairment, and re complete personal Assessment (CAA) indicated R229 req	MDS dated 8/29/16, included ntia and anxiety disorder. The ted R229 had severe cognitive quired extensive assistance to hygiene. The Care Area for ADLs, dated 8/29/16, uired assistance with all ADLs Dementia and Parkinsonian				
	R229's abilities with related to R229's d directed: "I may be Hand me my razor complete. I need y have my attention will I am unable to co	evised 11/23/16, identified a grooming were variable, iagnoses. The care plan e able to complete my shaving, and give me cues to ou to stand on my left side and when you are giving me cues, implete, I need staff to shave haved every morning."				
	R229 was ambulati the first floor. R229 approximately 1/8 i included longer stu 11/29/16, at 12:04 p the dining room for remained unshaver	on 11/28/16, at 3:45 p.m. ing in the dining room area on presented with facial hair, an nch growth, which also bbles under his chin. On p.m. while seated at a table in the noon meal, R229 n. Later at 7:22 p.m., R229 asleep in bed, with facial hairs shaven.				
	7:49 a.m. NA-D promorning cares in hi with toileting, wash	on 11/30/16, from 7:36 a.m. to ovided R229 with routine s room. NA-D assisted R229 ing, dressing, and brushing R229 returned to bed. R229				

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F 312	shave, during the p remained in his roo the dining room for unshaven. During interview on stated R229 was concentrated R229 was con	r was offered assistance to rovision of cares. R229 m until NA-D assisted R229 to breakfast at 9:12 a.m., still 11/30/16, at 1:46 p.m. NA-D urrently unshaven, and 9 was not offered shaving that cares. NA-D stated,"I just ted R229 was normally NA-D said R229 should be but [R229] just got missed." 11/30/16, at 2:04 p.m. urse (LPN)-C stated she rust the nursing aides would at R229 every day, and further, successful, to "let me know." and behaviors and involuntary erfered with completing ADLs, resistive to cares, but then always, always" keep trying,	F 31	2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 312	During observation was seated in his warea. R44 had visil fingers of both his have, "Really too lot trimmed shorter, but him to do it. During subsequent 1:18 p.m. and 11/30 continued to have hands. R44's care plan darrequired extensive complete grooming when it comes to clyou talk me through are doing." During interview on stated R44 was not care was typically obath. At 1:54 p.m. fingernails and stat should have been oproviding good hyghimself or others." During interview on stated she observe were, "A little bit lor him on his last bath them. R44's Treatment Advanced in his was seated and have been oprovided in the she observe were, "A little bit lor him on his last bath them.	on 11/28/16, at 3:02 p.m. R44 theelchair in the commons oly long fingernails on all hands. R44 stated his nails ng," and he would like them ut, "Not too many people" help observations on 11/29/16, at 0/16, at 1:45 p.m. R44 ong fingernails on both of his ted 11/26/16, identified R44 assistance from staff to tasks adding, "I am scared ipping my nails so I like it if in it and explain to me what you 11/30/16, at 1:51 p.m. NA-A resistive with cares and nail completed on during his weekly NA-A observed R44's ed they were, "Very long," and clipped because it was part of itene and so he, "Can't scratch of 11/30/16, at 2:00 p.m. LPN-A d R44's fingernails and they ng," and the nurse assigned to a day should have clipped	F 3	12		
	finger/toe nails wee	ekly with bath and PRN [as ord identified trimming of nails				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245518	B. WING		12/01/2016
	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD IEW HOPE, MN 55428	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 312	had been complete observed with long 11/26/16. A facility Resident C 1/2013, identified si with grooming AM a needs." Further, th	d two days prior to being fingernails by the surveyor on Care: Grooming policy dated raff would, "provide assist an PM according to resident e policy identified this included	F 312		
F 314 SS=G	Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received.	ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and	F 314		1/10/17
	by: Based on observate review, the facility for comprehensive assemble plan interventions for reviewed for pressure actual harm for this failed to consistent 1 of 3 residents (Resulters) R125's Admission Fidentified R125 was	ion, interview, and document ailed to conduct a ressment nor develop care or 1 of 3 residents (R125) are ulcers which resulted in resident. The facility also y monitor a pressure ulcer for 68) reviewed for pressure Record dated 8/16/16, admitted on 8/16/16. The n Data Set (MDS) dated		Preparation, submission and implementation of this Plan of Correct does not constitute an admission of or agreement with the facts and conclusi set forth in the statement of deficience. The facility has appealed the deficience and licensing violations stated herein. This Plan of Correction is prepared an executed as a means to continuously improve the quality of care, to comply all applicable state and federal regulat requirements and constitutes the faciliallegation of compliance.	ons es. es. d/or with ory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245518	B. WING		12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		.,
ST THER	RESE HOME			3000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 314	8/23/16, identified In pressure ulcers and (partial thickness to shallow open ulcer without slough. Ma open/ruptured blisticalso identified R125 assistance of two so Care Area Assessmidentified pressure condition, however findings/trigger nor considerations related The Braden Scale pressure ulcer risk) R125 as a moderated Tissue Tolerance (tappropriate reposite identified R125 had coccyx that were coand the balance of The Admission Obs 8/16/16, identified to 0.2 centimeters (charea and a 0.4 cm the coccyx ulcers. identified was that I Review of the physidentified wound catimes per week and cleanser and apply The Order Summa	R125 as being at risk for didentified three, stage 2 as of dermis presenting as a with a red-pink wound bed ay also present as an intact or er) pressure ulcers. The MDS as needing extensive staff with bed mobility. The nent worksheet (CAA) ulcers as a triggering, the CAA did not analyze the did it develop any care plan ted to pressure ulcers. (assessment to identify dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs) dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs) dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores. A dool used to determine ioning needs dated 8/16/16, identified the risk for pressure sores.	F 314	Persons responsible: Clinical Coordinators, RAI Coordinators, Eand/or designee. It is policy of St. Therese to ensure residents will not develop pressure unless the clinical condition demonsthe pressure sore unavoidable and necessary prevention and appropring treatment be provided to promote The "Skin Care Protocol" and "Presure and updated on 12/19/16 by the Alndirect Care. To assure continued compliance the following plan has been implement 1. R125 passed away on 9/24/16; plan review, treatment record review progress notes, and assessments reviewed by the DON. CAA was residued by the DON. CAA was residued by the DON. CAA was residued by the plan aligning with St. Therese plan aligning with St. Therese plan was completed. An audit was conducted on 12/22/16 on R68 to compliance with standard of care pressure ulcers. 2. Facility Wound Team and House Supervisor reviewed all current residuence with pressure-related injuries to en	e that e sores instrates d that riate healing. essure viewed DON of he ted: a care ew, were eviewed logue hospice e's care s ensure for	
	twice a week and a with wound cleanse	are to open area on coccyx as needed (PRN). Cleanse er, apply foam adhesive e nurse practitioner (NP)		comprehensive assessment, care with interventions and consistent monitoring of wounds, is in compli The "Skin Ulcer Audit" was complete.	ance.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	IOULD BE	(X5) COMPLETION DATE
F 314	progress note date nurses reported that her buttocks." The initial care plar pressure ulcer with to edema. The car interventions to prepressure ulcers of not identify any conaddition, the record facility developed a during R125's stay. A hospice plan of c9/21/16, identified date for this proble admission to the fa and nutritional deficassess actual/pote starting 8/11/16, ins skin breakdown, RI methods to prevencare PRN starting 8 to open area on cowheelchair. The holindividualized and to care plan individual plan of care did not Review of the week 8/16, 8/24, 8/31, 9/ pressure area to compressive	d 8/17/16, identified, "facility at pt [patient] has a wound on a dated 8/16/16, identified site being the coccyx related to plan did not include any event worsening of the current the coccyx. The care plan did incerns with the heels. In I lacked evidence that the comprehensive care plan	F 3	,	evisions continue to outs included on, quarterly, ge for all rategies breakdown. sment; ted to reeds. ensed staff re Protocol repolicies eted by and RAI ed on ments jury ritiated by mpleted 2 outs period of outs peri	
	documented - these Treatment plan: wo areas 2 times per v	sure areas above one e measure 0.2 cm x 0.2 cm. bund care to coccyx open veek and as needed (PRN). d cleaner and apply adhesive		4. Perform "Hospice/St. There Plan" audits on all residents or verify that hospice and St. The plans align by 1/9/17. Random be conducted, 1 per week, per	n hospice to erese care audits will	

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	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	The documentation notified on 8/16/16 The weekly wound address "mushy" at treatment/intervention as being red, almost Dressing on right hot open. A hospic "staff reports coccy However, this is co	interventions were identified. In identified the NP had been of the pressure ulcers. Idocumentation did not rea to heels, nor any ions. In 9/8/16, identified coccyx area at purple. Not opened. Ideal with left heel being red and e note dated 9/9/16, identified, x area is closed and purple." Inflicting to the weekly wound	F 314	days. The results of these reported to the QI/QA com revisions will be made per committee recommendation monitoring of pressure relancted in section 3 above.	mittee and QI/QA ons. Ongoing	
	A nursing note date wound team was as coccyx area. The trust cm skin tear to the (posterior superior as a hematoma with at noon to 3 and at 2.2 cm by 4.5 cm. was not related to posterior as a hematoma with at noon to 3 and at 2.2 cm by 4.5 cm. was not related to posterior as a hematoma with at noon to 3 and at 2.2 cm by 4.5 cm. was not related to posterior as a hematom as the skin causing a skin. A nursing note on 9 on right heel and the admission. Interver and dressing to heel indicated NP was the for coccyx wound. Ouse heel manager a hours, right heel has new order for dressing to the skin coccyx wound.	n/13/16, indicated intact blister at heels were mushy upon ntions to include, heel manager el. A follow up note on 9/13/16, nere with resident. New order Order included left heel boggy, and float, reposition every 2 is intact blister, left buttocks				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	for concerns of skir nurse. A physical er noted on the right hand a 100% eschar granulation tissue, covered wound not by 1 cm. as well as on the coccyx measurement pl follows: 1. Pressure ulcer or Patient had a foam dressing removed at the heel. The facilic concern and unsured orders for wound or cleanser, pat dry, a on bath day and Pf dislodgement. Heel and heel protectors 2. Pressure ulcer lead und heel protectors 2. Pressure ulcer lead und heel protectors 2. Pressure ulcer lead und heel protectors 3. Pressure ulcer lead und heel protectors 4. Pressure ulcer lead und heel protectors 5. Pressure ulcer lead und heel protectors 6. Pressure ulcer lead und heel protectors 7. Pressure ulcer lead und heel protectors 8. Pressure ulcer lead und heel protectors 9. Pressure ulcer lead und heel protectors 1. Pressure ulcer or Patient had a foam dean dean dean dean dean dean dean dean	entified R125 was being seen in integrity issues per the facility exam identified an intact blister neel measuring 2.2 cm by 2 cm or (composed of necrotic muscle, fat, tendon or skin) ed on the left buttocks 2.5 cm small clean open area noted suring 0.2 cm by 0.2 cm. an from the NP was as If heel, right stage 2: dressing on right heel. When an intact blister was noted on the ty nurse was unaware of this e of when it was noted. Fare were cleanse with wound pply foam dressing, change an intact blister while in bed is on while up in wheelchair.	F 31	4		

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	noted to be clean wound was identifit to measure due to Orders included he every shift and PR hours both while in pressure reduction wheelchair. The weekly wound identified a weekly identified a weekly identified the follow blister to the right stage 2 pressure to coccyx, and and 2 pressure ulcer 0. pressure ulcer 0. pressure ulcer to eschar - unstageal in which the base covered by slough. R125 was seen by no changes were reast developed by R125 passed away. During interview or registered nurse (Fibeen developed art to prevent the wors ulcers until 9/13/16.	coccyx, stage 2: pressure ulcer. The ulcer was with no signs of infection. The ed as having depth but unable the small size of the wound. Suse barrier cream with zinc N, turn and reposition every 2 a bed and in wheelchair and mattress and cushion for documentation on 9/14/16, wound documentation and wing: Theel first identified on 9/13/16. Theel first identified on 9/13/16. Theel first identified stage 2 cm by 0.2 cm by 0.0 other to coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified stage 2 cm by 0.2 cm by 0.0, therefore the coccyx identified the coccy	F 31	4		

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NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				800	REET ADDRESS, CITY, STATE, ZIP CODE O BASS LAKE ROAD W HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	have been interver admission and ong they should look at correct one for preserpositioning, cush DON stated the interverse included as needed pressure ulcers wo not been implement worsening. During interview or nurse practitioner (admitted with a knowled as deferred, about R125's heels other pressure ulcestated that she was 9/13/16, per the wortime she observed heel (it was a blisted the buttocks as we coccyx. She stated unstageable area a with a dressing. Slunaware of both of 13th of September areas, and verified worsened. The facility policy F	age 19 ations implemented upon oing. He stated the first thing is the mattress, if it is the ssure areas as well as ions, nutritional interventions. erventions should have been o see if they were effective and d. He verified that R125's resened and interventions had nted to prevent them from 12/12/16, at 2:30 p.m. the NP)-A stated R125 was own stage 2 coccyx pressure hat she did not visualize the licer on the day of admission, NP-A stated she did not know is being mushy or about the er on R125's buttocks. She is requested to look at R125 on ound team. She stated at this a stage 2 pressure ulcer to the er) and an unstageable ulcer to ll as the stage 2 ulcer to the did there was no dressing on the and the heel had been covered the stated the facility nurse was these areas. She stated the was the first she observed the the heel and buttocks had Pressure Ulcer Treatment one, identified the following	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLÉTION		
F 314	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			80	REET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R68's admission Mind 11/20/16, indicated the presence of a Sunopened nonbland R68's pressure ulce (CAA), dated 11/23. "nonblanchable red The CAA indicated monitored daily for Review of R68's facindicated the follow - On 11/13/16, at 2: documentation ider Later that day, at 9: noted on the right be (centimeters) x (by) - On 11/14/16, at 3: identified as "fragile facility's wound tear stage 1 pressure ul - On 11/22/16, at 12 was observed with maceration to wour were documented On 11/24/16, at 11 was observed with	ge 21 inimum Data Set (MDS), dated no cognitive impairment and stage 1 pressure ulcer (area of chable redness) on admission. er Care Area Assessment /16, identified a ness to her R (right) buttock." R68's right buttock was being changes. cility "progress notes" ing: 32 p.m. R68's admission ntified redness to the buttocks. 53 p.m. a scabbed area was auttock measuring 1.5 cm 0.6 cm. 07 a.m. R68's buttocks was but intact" indicating the m would evaluate and treat the cer. 2:54 p.m. R68's right buttock a "superficial open area of and edges." No measurements	F 3	14		RIATE	DAIL
	wound bed On 11/25/16, 11/2 buttock dressing wa wound bed was not - On 11/30/16, at 3: dressing was chang improving," howeve cm x 2.5 cm x 0.3 c	note did not describe the 6/16, and 11/27/16, R68's right as changed, however, the described. 13 p.m. R68's right buttocks ged and was "Noted to be er, the wound measured 5.5 cm deep. The note classified etween stage 1 and 2."					

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	PROVIDER OR SUPPLIER			800	REET ADDRESS, CITY, STATE, ZIP CODE 10 BASS LAKE ROAD W HOPE, MN 55428	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	the pressure ulcer.	es lacked daily monitoring of	F3	14			
	assessment, dated pressure ulcer was The assessment in had increased to a measuring 2 cm x 1 wound bed consisti granulation (healthy (necrotic tissue that addition, the assess developed a new st left buttock measur deep consisting of 25% slough. Both a	Nound Documentation 11/28/16, indicated the first identified on 11/13/16. dicated R68's right buttock stage 2 pressure ulcer 1.5 cm x 0.3 cm deep with a ng of 75% (percent) y) tissue and 25% slough t doesn't promote healing). In sment indicated R68 had age 2 pressure ulcer on the ing 1 cm x 0.5 cm x 0.2 cm 75% granulation tissue and assessments were inconsistent to notes and the previous essure ulcer.					
	"Monitor pressure u "Document weekly identify a pressure During observation licensed practical n dressing to right bu soiled dressing, LP looked much better superficial, consistin contain slough, and peeling skin. LPN-E as 5.5 cm long x 2 to measure the lengulcer on R68's lowe intact reddened skin	ure plan, undated, directed to alcer to R buttock daily" and on status of ulcer." It did not ulcer on the left buttock. on 11/30/16, at 9:40 a.m. urse (LPN)-B changed R68's ttock. After removing the N-B stated R68's right buttock, the wound bed was ng of healthy tissue, did not I was surrounded by reddened B measured the pressure ulcer cm wide. LPN-B was observed of the open area of the er buttock up to the area of n on the upper buttock (the did not measure the length					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	from open end to o she measure the do observation. In add left buttock and statintact. During interview on LPN-B stated the rimiddle (the pressure deeper than the redit; however she "Puall as one. During observation registered nurse (Fland measured right cm x 1.5 cm x 0.4 cpressure ulcer was slough. In addition, the pressure was rewould still be consistated R68's left buredness and was in During interview on stated R68's pression 11/22/16 by the opened and progrestated the right butt measurements for were incorrect, furth should be measure periwound. RN-C spressure ulcer on the wound assessmincorrect. During interview on the wound interview on the wound assessmincorrect.	pen end of the ulcer nor did epth of the ulcer during the ition, LPN-B observed R68's ted the skin was healed and 11/30/16, at 11:56 a.m. ght buttock had an area in the re ulcer) that looked slightly dened superficial skin around t it all together" measuring it on 12/1/16, at 9:31 a.m. N)-C performed wound cares to buttock pressure ulcer 1.1 cm deep. RN-C stated the superficial and did not contain RN-C stated the skin around eddened, dry, and peeling, but dered the periwound. RN-C ttock contained blanchable	F 31	4		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	COMPLETED	
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F 323 SS=D	weekly with measur monitoring should on how the wound bed changes. RN-D statemeasuring pressure RN-D reported wou assessments, and raccurate to ensure and to prevent infect A facility policy entity 4/10, directed nurse "Document the asse Weekly Wound Dood directed staff to per pressure ulcers, who ulcer if no dressing dressing, status of spresence of possibly 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on observative review, the facility fassess safety with several accidents.	e ulcers daily and charting rements. RN-D stated the daily consist of the drainage, odors, I looks, and if there are any ted inconsistencies in e ulcers was an ongoing issue. Individual inconsistencies in end measurements, monitoring needed to be the right treatment is ordered extions. Itled Skin Care Protocol, dated extions. Itled Skin Care Protocol, dated extions weekly on the cumentation" and specifically form daily monitoring of extinct included "Evaluation of the present, evaluation of surrounding area, and the complications."	F 3		es,	1/10/17
	(R337) identified to	be currently smoking while at				

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	PROVIDER OR SUPPLIER			80	REET ADDRESS, CITY, STATE, ZIP CODE 00 BASS LAKE ROAD EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	the facility. Findings include: R337's admission of dated 11/16/16, ide cognition. R337's Transitional dated 11/22/16, ide the transitional care identified several di "Tobacco use disor identifying, "Nursing sometimes goes ou During observation was seated on her from the street to the facility. R337 wand had no oxygen When interviewed or receptionist (RCP)-smoke and has to greatly because shon campus. R337's progress not entries: On 11/9/16, "shountil she could go of On 11/10/16, "shountil she could go of On 11/16/16, "shountil she of On 11/16/16, "shountil she of On 11/16/16, "shountil she	Minimum Data Set (MDS) ntified R337 had intact Care Follow-Up Visit note ntified R337 was residing in a unit at the facility. The note agnoses which included, der," with further dictation g staff report that patient at to smoke." on 12/1/16, at 7:55 a.m. R337 electric scooter coming up the main outside entrance to as dressed in a light sweater	F3	23	It is the policy of St. Therese to creenvironment that focuses on the sall residents. St. Therese continue maintain a smoke-free campus. 1. R337 has been discharged on 12/2/2016. 2. Residents who actively participal smoking will continue to be identified admission during the initial interviec completed by Social Services. Nursincorporate questions to identify rewho smoke in the Admission Obset Assessment. The Admission Obset Assessment was revised and implemented on 12/23/16. A review current residents was completed to identify and assess any other smooth the facility and their safety with smooth facility and their safety safety facility and their safety facility and their safety facility and their safety	afety of s to ate in ed upon w sing will sidents rvation rvation w of all occurs in oking. Oking ety be oke on. and lentified I. This ts. An	

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245518	B. WING			12/	01/2016
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	she [R337] is aware planning to take he Lake Road to smok not recommend she R337's medical recany identified compensure R337 was supervision, to detewere required to enusupervised smok R337's care plan dawas a smoker and, non-smoking." The have decreased reand listed interventi R337 to have friend smoking and to kee from oxygen tanks. During interview on stated she had bee morning when the scoming inside. She smoke multiple time goes, "Down by the smoke. R337 state cigarettes in the rod oxygen. R337 state with her if they are herself. Further, R3 smoking on her ow gone outside to obsher about her ability	e of this and that she is relectric scooter down to Bass relection with the state of the same	F3	323			
	assistant (NA)-K sta	ated R337 goes out to smoke g her shift by herself, "She					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	· /	E SURVEY PLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 356	was safe to smoke could dress herself. During interview on registered nurse (Routside on her own suspected she was smells like smoke vRN-F stated R337 hadmitted to the nursher it was a non-smemoved. RN-F stated ever been assess unsupervised smoked be a good thing to cherself" potentially it to drop it or have a During interview on registered nurse (Rosmoking while in the and being warned, right outside the froherself out when shand being warned, right outside the froherself out when shand being warned, right outside the froherself out when shand being warned, right outside the froherself out when shand being warned, right outside the froherself out when shand because it however, added R3 assessed to ensure unsupervised because fire or burn herself acility did not have was, "In progress."	"NA-K stated she felt R337 on her own because she "I think she can do it." 12/1/16, at 9:03 a.m. N)-F stated R337 goes at times adding staff smoking because she often when she comes back inside. In ad a lighter when she sing home, however staff told toking campus and it was sted she was unaware if R337 essed for her safety with ing, however, added it would do because R337, "Could burn of she was smoking and were problem. 12/1/16, at 10:31 a.m. N)-D stated R337 had been a facility since her admission "Several times" about smoking and doors and not signing a goes outside consistently.	F 32			1/10/17	
SS=C	INFORMATION	st the following information on	F 30			1/10/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245518	B. WING		12/0	1/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	,, •	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 356	by the following cat unlicensed nursing resident care per sland resident cansus. The facility must pospecified above on of each shift. Data on Clear and readaboon in a prominent pland residents and visito. The facility must, up make nurse staffing for review at a cost standard. The facility must make nurse staffing data for an required by State later this REQUIREMENT by: Based on observation review, the facility fistaffing information could be easily review.	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. Set the nurse staffing data a daily basis at the beginning must be posted as follows: le format. acce readily accessible to rs. Soon oral or written request, g data available to the public not to exceed the community aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced tion, interview and document ailed to post the required daily in a prominent place where it ewed. This had potential to ents, visitors and staff who	F 350	Persons responsible: Staffing persons responsible: Staffing persons Receptionist, DON and/or designed It is the policy of St. Therese to ensure that staffing information is accessible residents, visitors, and staff. The "Staffing: Posting of Nursing Hours"	e. sure ole to all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245518	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 356	Findings include: During a tour of the p.m. the main entra sitting on top of a d most recent survey located in a marked lobby." At the opport closed white binder which was labeled and, "Posted Daily required staffing infollosed white binder were no further postacility staffing hour. During subsequent 1:41 p.m. the required sagain contained the desk in the main posted documents hours in the main low. When interviewed a staffing supervisor placed in the binder different people chases. A stated she was information was composted for residents adding it had been the past several moduling interview on administrator stated the staffing informal and she was unaway.	facility on 11/29/16, at 1:05 ince had a framed document resser which identified, "The results and staffing hours are dibinder at the end of the main osite end of the main lobby a was placed on a small desk to contain past survey results Staffing," information. The ormation was contained in the behind the cover. There sted documents to identify the sin the main lobby. observation on 11/30/16, at red daily staffing information d in the closed white binder on a lobby. There were no further to identify the facility staffing obby. on 11/30/16, at 2:16 p.m. (SS)-A stated the posting is a for each shift with three anging it on a daily basis. It is unaware why the staffing ontained in a binder and not is and visitors to easily review, placed in the white binder for	F 356	has been reviewed on 12/19/16 ar changes made as necessary by Al Indirect Care. 1. No known residents were direct impacted by the location of the nurstaffing information posting. 2. No known visitors were directly impacted by the location of the nurstaffing information posting. 3. Nursing staffing hours are post location and height that is accessification for all departments of 12/23/16. Education for all departments of 12/23/16. Education for all departments of 1/9/17. 4. Random audits will be conducted for one month, to ensure nursing hare posted accessibly beginning 13	DON of tly rse ed in a ole to all nours f nents on will ed daily nours	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	` '	E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	A facility Nursing Ho 8/2011, identified a "Per the regulation,	purpose of posting the hours, and directed staff to post the n white 3 ring binder across ors office."	F 356			
F 371 SS=F	483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food fro considered satisfac authorities; and	OCURE, 'SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 37			1/10/17
	by: Based on observat review, the facility for kitchen environmer stored uncovered a production kitchens 216 residents who is Findings include: During observation 11/28/16, at 10:32 a and three large met observed uncovere	ion, interview, and document ailed to provide a sanitary at with unclean mixing bowls and on the floor for 1 of 2 which served meals to 216 of receive food from this kitchen of the residence kitchen on a.m. two large standing mixers all mixing bowls were d and stored on the floor while pe metal bowl was resting on a		It is the practice of St. Therese to prepare, store, distribute and serve under sanitary conditions. 1. No known residents were affected this practice. 2. No known residents were affected this practice. 3. The mixing bowl storage procedure been updated. New 40-60 bowls storage procedure was put in to place. The process now is to cover clean, dry to bowls with a clean food service bag not use food service film. On 12/10 two additional mixing bowl trucks (but the process to the process food service film.	ed by ed by ure has torage e mixing g and 0/16	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	The bowl was unco crumbs were obser During observation removed the bowl, member, and instrucrumbs stating the bowl during meal production of the metal mixing bowls sitting directly on the liquid substance was and sides of the bowas covered. During interview on stated the white subbowls was from mastated the staff use tried to "Wipe them day. DM-A further scleaned once a day when not being used During observation two mixing bowls were on round metal rollic covered with clear pliquid substance was top of the cling wrated to "During interview on (C)-A stated the measually stored covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with measually stored covered with covered was to possible to the cling wrated the measually stored covered with covered covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with clear pliquid substance was top of the cling wrated the measually stored covered with covered with clear pliquid substance was top of the cling wrated was the measurement of the covered with covered with clear pliquid substance was top of the cling wrated was the covered with clear pliquid substance was top of the cling wrated was the covered with clear pliquid substance was the covered wa	stand under a standing mixer. vered and several brown ved in the bottom of the bowl. dietary manager (DM)-A handed it to a dietary staff acted them to clean out the crumbs must have fallen in the reparation from a nearby distanding mixer was ite liquid substance splattered e mixer. Next to the mixer, two, one on top of the other, were e ground. The same white as splattered along the bottom th mixing bowels. Neither bowl 11/28/16, at 10:32 a.m. DM-A betance on the mixer and alking mashed potatoes. DM-A the mixers "All the time," and down as needed" during the stated the mixers should be and were not stored covered ed. on 12/1/16, at 10:14 a.m. only were present in the kitchen. The observed off the floor resting ng stands and were observed of astic cling wrap. A white as observed splattered on the	F 371	dollies) were purchased, to he proper storage. Staff training and documented on 12/19/16 storage of mixing bowls. 4. Audit sheets were made to storage of mixing bowls. Audit done two times per week for 3 starting on 12/22/16.	was started for proper audit clean its will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 371 F 441 SS=D	stated food "Gets flit to the top of the clin there were mashed DM-A further stated twice everyday and wrap over the bowls keep it covered, that A facility policy entit Mixing Bowls, unda bowls on the "Wheeto "Cover clean bowhelp prevent items infection and mainta 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Presafe, sanitary and control to help prevent the of disease and infection Control The facility must es Program under whice (a) Infection Control The facility must es Program under whice (1) Investigates, control the facility; (2) Decides what preshould be applied to (3) Maintains a recontrol to the preventing Spresential Control The facility; (2) Decides what preshould be applied to (3) Maintains a recontrol to the preventing Spresential Control The facility; (2) Decides what preshould be applied to (3) Maintains a recontrol The facility; (2) Decides what preshould be applied to (3) Maintains a recontrol The facility; (2) Decides what preshould be applied to (3) Maintains a recontrol The facility; (3) Maintains a recontrol The facility; (4) Decides what preshould be applied to (3) Maintains a recontrol The facility; (4) Decides what preshould be applied to (4) When the Infect determines that a recontrol The facility is the facility of the fac	12/1/16, at 10:19 a.m. DM-A ung around so much" pointing g wrap and furthered stated potatoes on the top of it. I mashed potatoes were made she had placed the clear cling thinking "That was safer to the was my fix for it." Iled Storage of 60 Quart ted, directed staff to place the eld dollies" for easy moving and which with food service film, to from falling into bowls, prevent ain cleanliness of the bowls." I CONTROL, PREVENT I CONTROL, PREVENT I CONTROL, and transmission ction. I Program tablish an Infection Control chit—ntrols, and prevents infections occedures, such as isolation, or an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to	F 4			1/10/17
	(1) When the Infect determines that a re	ion Control Program				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	communicable dise from direct contact direct contact will tr (3) The facility mushands after each dihand washing is inc professional practic (c) Linens Personnel must hat transport linens so infection. This REQUIREMENT by: Based on observative, the facility for the second of the s	t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44	Persons responsible: ADON of Inc Care and/or designee	direct	
	11/20/16, indicated ulcer (open wound During observation licensed practical n gloves on her hand prior to donning. Stransved R68's soil the soiled dressing, small amount of se	inimum Data Set (MDS) dated the presence of a pressure related to pressure.) on 11/30/16, at 9:40 a.m. urse (LPN)-placed a pair of s and did not wash her hands he then placed another pair of eady gloved hands. LPN-B ed dressing. After removing LPN-B stated it contained a rous (pale yellow color) s wound. LPN-B discarded the		It is the policy of St. Therese to utili proper hand washing and gloving washing and gloving conducting procedures. Our "Infect Control: Use of Gloves" and "Infect Control: Hand Hygiene" policies has been reviewed by ADON of Indirect 1. No adverse outcome was noted R68. 2. A scenario/audit will be present randomly selected group of license nurses involving wound care and go procedure. This data will be report the QI/QA committee. This will occur during all shifts/all units everyday for days. Any corrective action will be	while ction tion ave ct Care. d for ed to a ed gloving ed to cur	

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245518	B. WING _		12/	01/2016
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP CO 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	soiled dressing, wa R68's wound then rof gloves. LPN-B prodressing while wear potentially contamir new dressing over the hands should hole between changing to LPN-B further state glove and not the factor of the produced and changed and changed ressings. RN-D further stated and ressings and responsible for the stated and restricted and restricted and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed and restricted staff to remon-contaminated in the facility policy Indated 2/10, directed staff to remon-contaminated in the facility policy Indated 2/10, directed staff to remon-contaminated in the facility policy Indated 2/10, directed staff to remon-contaminated in the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remone the facility policy Indated 2/10, directed staff to remon	shed, dried, and measured emoved one of the two pairs roceeded to open the new ring the second pair of nated gloves and placed the R68's wound. LPN-B stated ave been washed immediately res and would usually wash in the dirty and clean dressings. It is policy. 12/1/16, at 11:47 p.m. N)-D stated gloves should be ged in between dirty and clean rther stated it was not the puble glove and staff received or hand hygiene during wound and annually. 12/1/16, at 2:46 p.m. RN-E double gloving is not as not taught by the facility. It the observation provided an education." Infection Control: Use of Gloves of staff to change gloves in the same resident after Contact may contain a high croorganisms. It further nove gloves before touching	F 44	immediately addressed with point of care, if necessary, un compliance is achieved as dethe QI/QA committee and the recommendations. 3. Educate licensed nurses and the reinforce the expectation that policies need to be followed. training on these policies will completed by 1/9/17. 4. Complete random "Gloving licensed nurses for proper glidressing changes. These with conducted randomly on each unit for 30 days. Any corrective immediately addressed with point of care, if necessary, un compliance is achieved as dethe QI/QA committee and the recommendations.	ntil etermined by eir and NA/Rs d above and t the facility's This formal be g" audits on oving and Il be o shift/each ve action will ith staff at the ntil etermined by	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY PLETED	
		245518	B. WING _		12/	01/2016	
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	,	12/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 465 F 465 SS=C	483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pr	AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 46			1/10/17	
	by: Based on observative review, the facility of kitchen environmer production kitchens effect 216 of 216 refrom this kitchen. finding include: During observation 11/28/16, at 10:32 awere observed on a area. One mounted toward the clean side three tier metal rolli observation, two raserving utensils and of the dishwasher of fan. When turned owere covered with lextending from the During interview on stated the thick graand the fan "Needs maintenance took at them once a month."	NT is not met as evidenced tion, interview, and document ailed to provide a sanitary at with dirty wall fans for 1 of 2 s which has the potential to esidents that receive meals of the residence kitchen on a.m. two wall mounted fans and blowing in the dishwashing af fan was observed blowing de of the dish area where a ling cart stood. During cks of clean dishes, containing diclear plastic jugs, came out on a conveyor belt toward the lift, the wire rings of the fan hanging thick gray fuzz middle to the back of the fan. 11/28/16, at 10:32 a.m. DM-A y substance "Looks like fuzz" to be cleaned." DM-A stated apart the fans and cleaned but that one "Must've been ther stated the cleaned wet		It is the practice of St. Therese a safe, functional, sanitary, and comfortable environment for resistaff and the public. 1. No known residents were hat this practice. 2. No known residents were hat this practice. 3. The Plant Operations departing preventative maintenance progrescleaning was updated to include disassembly. The new date for disassembly of the fans will be the Wednesday of each month. This information was put in Outlook to help remind staff about month cleaning of wall fans. The clean fans procedure has been update training about proper monthly we cleaning audits have been creat Audits will be conducted monthly months; this is in Outlook calend the audits monthly.	rmed by rmed by rmed by ment am for fan fan monthly he last is calendars hly ing of wall ed. Staff all fan I fan ed. y for 6		

AND DUAN OF CODDECTION IN IDENTIFICATION NUMBER.		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245518	B. WING _		12	/01/2016
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP COE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465	dishes were stored afternoon to dry the During observation fan was observed of During interview on stated that particula others and couldn't DM-A states "I would it only got half done clean the fan. DM-A expect staff to reme cleaned differently of A facility policy entitundated, directed me guards monthly; how dietary staff to wipe wash the fan guard "Clean fans help profood and food service."	on the the metal cart in the en put away at night. on 12/1/16, at 10:14 a.m. the eleaned without any gray fuzz. 12/1/16, at 10:19 a.m. DM-A ar fan was different than the be taken apart to be cleaned. Idn't say it got missed, I'd say at a staff had to climb up to a further stated she would ember that fan needs to be when completing the task. Iled Cleaning of Wall Fans, naintenance to remove the fan wever, the policy directed the off dust and dirt build up and s. The policy further directed event dust being moved onto ce equipment."	F 46	65		

F 5518025

PRINTED: 01/23/2017 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245518 B. WING 11/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 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

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.

AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245518	B. WING		11/	/30/2016
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME				STREET ADDRESS, CITY, STATE, ZIP COD 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	By email to: Marian.Whitney@s Angela.Kappenman THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of vactories to correct the deficit 2. The actual, or proceed to correct the deficit 3. The name and/or responsible for correct a reoccurrence of the sement. The bud different times. The constructed in 1968 Type I (332) constructed to determined to be on 1999, an addition was constructed in 2003 was determined to the 3rd floor was d	tate.mn.us and n@state.mn.us RRECTION FOR EACH TO INCLUDE ALL OF THE DRMATION: what has been, or will be, done lency. oposed, completion date.	KO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245518	B: WING		11/3	30/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pathe time of the surv	-	K 000			
K 521 SS=E	NOT MET as evide NFPA 101 HVAC HVAC Heating, ventilation	, and air conditioning shall d shall be installed in e manufacturer's	K 521			12/23/16
	Based on observa facility's heating, ve in not in compliance 9.2, 19.5.2.1 and No practice could effect second floor. Findings include: On a facility tour be 1530 on November revealed that the heat conditioning system of the 1968 building as part of the air diair plenum through	is not met as evidenced by: tion and staff interview, the entilation, and air conditioning e with the 2012 LSC NFPA 101 IFPA 90A. This deficient ct all residents on the first and etween the hours of 1000 and a 30, 2016, observations eating, ventilation and air as for the first and second floor g are using the corridor system stribution system as a return the bathroom exhaust.		A: A continuing waiver is be for K521. Compliance with twill cause an unreasonable accordance with SOM 2480 the cost estimate for comply system dated 4/8/2014 is \$7 Financing costs at 5% add \$272,768 to the project. Unreimbursement rates, we estakes up to 50 years to recosts. The installation and work of the new ventilation also severely impact the resto move about the facility arquality of life with the constructions. The with a fixed, solid corridor coinstallation options because headroom that would result ductwork. The current ceiling	his provision hardship in C because: ying HVAC I,000,000. an additional der the current stimate that it toup the project construction system would sident's ability and effect their ruction noise, building design eiling limits of inadequate in adding	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245518	B. WING		11/3	30/2016
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO 2000 BASS LAKE ROAD NEW HOPE, MN 55428	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 521	Continued From pa	age 3	K 521	feet, the addition of ducts an materials would reduce the hess than 6'5". The building i years old and strategic plant organization has begun for this building. B: There will be no adverse building occupants safety in with SOM2480B, because S Home is a 3-level, Type-II bustructure with interior finish reflame 20 and smoke 85 on the flame 25 and smoke 45 on the and flame 15 and smoke 30 floor. The walls, floors, ceilin vertical openings were design constructed to resist the pass smoke. There are three smooth compartments on each floor training for staff on the facilities affety plan is conducted facility is fully sprinkled. A fire procedure is implemented where alarm or fire sprinkler sy for maintenance, repair or une plant Operations Supervisor designated and trained for one fire Watch procedure when Documentation of Fire Watch p	neadroom to s currently 48 hing for the he future of effect on the accordance aint Therese uilding ratings for: he first floor, he 2nd floor, on the 3rd ags and gned and sage of oke of the facility. It compliant annually. The e watch whenever the stem is down pgrades. The has been conducting the necessary. The necessary of the facility is conducting the necessary. The necessary of the facility is conducting the necessary of the necessary. The necessary of the necessary. The necessary of the nec	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245518	B. WING			11/3	0/2016
	PROVIDER OR SUPPLIER	1		80	REET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD EW HOPE, MN 55428		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 521	Continued From pa	ge 4	K 5	521	from the MN Fire Marshall office. T facility staffing ratio is 1 staff per 1. residents in a 24 hour hour period.		
		or .					

St. Therese Home

PART III - RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s). 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

PROVISION NUMBER(S)	JUSTIFICATION
K400	A) A continuing waiver is being requested for K521. Compliance with this provision will cause an unreasonable hardship in
7604	accordance with SOM 2480C because:
The building Desting	• The most cost estimate for complying HVAC system dated 4/8/2014 is \$1,000,000.00. Financing costs @ 5% add an
\/entilation &	additional \$272,768.00 to the project.
Vir Conditioning	 Under the current reimbursement rates, we estimate that it take up to 50 years to recoup the project costs.
Equipment (HV/AC)	 The installation and construction work of the new ventilation system would also severely impact the resident's
does not comply with	ability to move about the facility and affect their quality of life with the construction noise, dust and obstructions.
LSC (00) Section 9.2	 The building design with a fixed, solid corridor ceilings limits installation options because of inadequate `head
and NFPA90A, 1999	room' that would result in adding ducting. The current ceiling height is 8 feet, the addition of ducts and ceiling
Ed. because the	materials would reduce the head room to less than 6 foot 5 inches.
corridors are being	 The building is currently 48 years old and is slated for replacement in 2018.
used as a plenum	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

Thomas Linhoff 12424 A Supervisor	Fire Authority Official (Signature) Title	Surveyor (Signature) Title
or State Fire Marshal Division	Office	Office
01-23-2017	Date	Date

The walls, floors, ceilings and vertical openings were designed & constructed to resist the passage of smoke.

the 1st floor -flame 25 and smoke 45 on the 2nd floor --flame 15 and smoke 30 on the 3rd floor.

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	(B continue)
K521	 There are 3 smoke compartments on each floor of the facility.
The building Heating	 Training for staff on the facility compliant `Fire Safety Plan' is conducted annually.
Ventilation &	• The facility is fully sprinkled.
Air Conditioning	 A "Fire Watch" procedure is implemented whenever the fire alarm or fire sprinkler system is down for maintenance,
Equipment (HVAC)	repair or upgrades. The Plant Operations Supervisor has been designated and trained for conducting the fire watch
does not comply with	procedure when necessary. Documentation of fire watch rounds are available for review.
LSC (00) Section 9.2	 The fire department station is 2 miles away and has an average of a 3 minute response time.
and NFPA90A, 1999	 The fire alarm systems (pull stations, smoke /heat detection & notification devices) have been updated to include
Ed., because the	`addressable' technology throughout.
corridors are being	 Monthly fire drills are conducted and documented on all 3 shifts for staff.
used as a plenum	 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.

Thomas Linhoff 12424 & Santy	File Authority Official (Signature)	Surveyor (Signature)
Fire Safety Supervisor	Title	Title
State Fire Marshal Division	Office	Office
01-23-2017	Date	Date



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



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 <u>only a suggestion</u> 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

St. Therese Home December 15, 2016 Page 2

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	99994		B. WING	-	10/01/0010	
		00261	b. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER			ļ	
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I	Minnesota Statute, section otion order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation oe assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/23/16

STATE FORM 6899 If continuation sheet 1 of 36 ZLT211

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00261	B. WING		12/0	1/2016
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040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	PE, MN 5542		ON!	0/5)
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2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for State enter the word "corrected. You must then State licensure proceedings of the corrected prior to elected prior to elec	n 2016, through December 1st this Department's staff, rovider and the following re issued. Please indicate in of correction that you have ers, and identify the date when				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The appears in the far le Tag." The state stalisted in the "Summ column and replace the correction order the findings which a statute after the statute after the statute as evidence by." For are the Suggested Time period for Correction of Completed and four PLEASE DISREGATOURTH COLUMN	complaint H5518070 was nd not to be substantiated.				

Minnesota Department of Health

APPLIES TO FEDERAL DEFICIENCIES ONLY.

STATE FORM 5699 ZLT211 If continuation sheet 2 of 36

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00261	B. WING		12/01/2016	
8000 BAS	S LAKE RO	AD		
MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
R ON EACH PAGE. UIREMENT TO SUBMIT A TION FOR VIOLATIONS OF	2 000			
nent. A nursing home must ensive assessment of each nich describes the resident's a daily life functions and ints in functional capacity. A conducted according to section 148.171, subdivision part of the comprehensive it. The results of the dent assessment must be view, and revise the resident's it of care as defined in part attion gathered. The dent assessment must following information: sined conditions and prior as measurement; mental functional status; physical impairments; and requirements; ments or procedures; psychosocial status; pertial; portential; portential; potential; us;	2 540			1/10/17
	00261 STREET AD 8000 BAS	O0261 STREET ADDRESS, CITY, S 8000 BASS LAKE RO NEW HOPE, MN 5542 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION) TAG TO NEACH PAGE. UIREMENT TO SUBMIT A TION FOR VIOLATIONS OF E STATUTES/RULES. Subp. 1 & 2 Comprehensive Int Intent. A nursing home must ensive assessment of each nich describes the resident's Indially life functions and Ints in functional capacity. A It conducted according to section 148.171, subdivision part of the comprehensive Int. The results of the Ident assessment must be View, and revise the resident's Intention of care as defined in part Ition gathered. The Ident assessment must Ition gathered. The Identical indications and prior Ition gathered. The Identical indications is in the indication in the indication in the i	Dentification number: 00261 B. WING	Dentification number: 00261 B. WING

Minnesota Department of Health

STATE FORM 5899 ZLT211 If continuation sheet 3 of 36

Minnesota Department of Health

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 3	2 540			
	by: Based on interview facility failed to comresidents skin care	and document review the aprehensively assess a needs for 1 of 3 records viewed for pressure ulcers.		These orders have been reviewed be corrected	d and will	
	Findings include:					
	assessment dated having three stage dermis presenting a red-pink wound becomesent as an intact blister) pressure ulcadmission. The ad	ers that were present upon mission MDS assessment y Care Area Assessment e identified skin				
	assessment of R12 (assessment to ide 8/16/16, identified F pressure sores. A 8/16/16, identified r areas on coccyx that dressings and the k was intact. The Ad Observations/Assection identified two stage 0.2 centimeters (cm area and a 0.4 cm light the coccyx ulcers. The Order Summan	ssment dated 8/16/16, 2 pressure ulcers measuring n) by 0.2 cm on the coccyx by 0.4 cm stage 2 area below The assessment also identified				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THER	ESE HOME		S LAKE ROA PE, MN 5542			
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2 540 2 565	with wound cleansed dressing PRN. The progress note dated nurses reported that her buttocks that she laying back down in During interview on director of nursing vassessment had be CAA should have be SUGGESTED MET. The director of nursiculd review policy regarding completic comprehensive rescare area assessment cand Assurance (QA random audits to er TIME PERIOD FOF (21) days. MN Rule 4658.0405 Plan of Care; Use Subp. 3. Use. A constitution of the progression of the	s needed (PRN). Cleanse er, apply foam adhesive en urse practitioner (NP) d 8/17/16, identified "facility at pt [patient] has a wound on ne will be evaluating once pt is a bed." 12/1/16, at 1:35 p.m. the verified no comprehensive een completed and that the een done. THOD FOR CORRECTION: sing (DON) and/or designee and provide education for staff on of an individualized ident assessment including ents for admission, annual nges. The Quality Assessment (A) committee could donsure compliance. R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive	2 540			1/10/17
	care of the resident	personnel involved in the				

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
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ST THEF	RESE HOME		S LAKE RO			
			PE, MN 5542	T		
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2 565	Continued From pa	ge 5	2 565			
	review, the facility	on, interview, and document ailed to implement the care ents (R229) reviewed for ng (ADLs), who was aff for hygiene.		These orders have been reviewed be corrected	l and will	
	Findings include:					
	Minimum Data Set dementia and anxie Assessment for AD R229 required assis	as indicated on the admission dated 8/29/16, included by disorder. The Care Area Ls, dated 8/29/16, indicated stance with all ADLs due to ia and Parkinsonian tremor.				
	R229's abilities with related to R229's di directed: "I may be Hand me my razor of complete. I need you have my attention will am unable to co	evised 11/23/16, identified a grooming were variable, agnoses. The care plan able to complete my shaving and give me cues to but o stand on my left side and when you are giving me cues. I need staff to shave haved every morning."				
	R229 was ambulating the first floor. R229 approximately 1/8 in included longer stubent 11/29/16, at 12:04 puthe dining room for remained unshaver	on 11/28/16, at 3:45 p.m. ng in the dining room area on presented with facial hair, nch growth, which also obles under his chin. On o.m. while seated at a table in the noon meal, R229 n. Later at 7:22 p.m., R229 asleep in bed, with facial hairs shaven.				
	7:49 a.m. nursing a R229 with routine m	on 11/30/16, from 7:36 a.m. to ssistant (NA)-D provided norning cares in his room. 9 with toileting, washing,				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. Bolesina.				
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	R229 returned to be was he offered assiprovision of cares. until NA-D assisted breakfast at 9:12 a. During interview on assistant (NA)-D saunshaven, and acknoffered shaving this NA-D said,"I just forwas normally shave	orushing teeth, after which ed. R229 was not shaved, nor istance to shave, during the R229 remained in his room R229 to the dining room for m., still unshaven. 11/30/16, at 1:46 p.m. nursing aid R229 was currently nowledged R229 was not a morning during his cares. It is in NA-D stated R229 ed every day. NA-D said R229 everyday, "but [R229] just got				
	licensed practical nexpect and trust the shave R229 every consuccessful, to "le R229 had behaviors that interfered with R229 could be resis "we should always, document refusals." During interview on director of nursing (the aides to follow to residents as needed expected the nurse ensure routine care. A facility policy, Resplanning, dated Fel purpose "To provide	12/1/16, at 1:07 p.m. the (DON) said he would expect heir care guide and shave d. The DON also stated he s in charge to monitor staff to				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/01/2016	
_	PROVIDER OR SUPPLIER	8000 BAS	S LAKE RO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	SUGGESTED MET director of nursing (review or revise pol staff regarding care Quality Assessment committee could do compliance.	ge 7 HOD OF CORRECTION: The DON) and/or designee could icies, provide education for plan implementation. The t and Assurance (QAA) random audits to ensure	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.		2 830			1/10/17
	by: Based on observati review, the facility for assess safety with s	ent is not met as evidenced on, interview and document ailed to comprehensively smoking for 1 of 1 residents be currently smoking while at		These orders have been reviewed be corrected	and will	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00261	B. WING		12/0	1/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST THEF	RESE HOME		S LAKE RO				
			PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ige 8	2 830				
		Minimum Data Set (MDS) entified R337 had intact					
	dated 11/22/16, ide the transitional care identified several di "Tobacco use disor	Care Follow-Up Visit note entified R337 was residing in e unit at the facility. The note iagnoses which included, eder," with further dictation g staff report that patient ut to smoke."					
	was seated on her from the street to the	on 12/1/16, at 7:55 a.m. R337 electric scooter coming up ne main outside entrance to vas dressed in a light sweater in place.					
	receptionist (RCP)- smoke and has to g	on 12/1/16, at 7:58 a.m. the A stated R337 goes outside to go down by, "Bass Lake e was not allowed to smoke					
	entries: - On 11/9/16, "she until she could go or - On 11/10/16, "sprisks of smoking and using oxygenmac - On 11/16/16, "re went outside" - On 11/29/16, "spregarding smoking she [R337] is aware planning to take he	e [R337] refused to eat supper outside and have a cigarette." poke to resident about the nd using butane lighter while de promise not to smoke." esident able to wheel self and poke with resident on this date outside on campus stated e of this and that she is relectric scooter down to Bass see. Writer stated that we do					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	1/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ST THER	RESE HOME		S LAKE ROA E, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 9	2 830				
	any identified compensure R337 was a supervision, to determine were required to en unsupervised smoken R337's care plan day was a smoker and, non-smoking." The have decreased read listed intervention R337 to have friend smoking and to kee from oxygen tanks. During interview on stated she had bee morning when the scoming inside. She smoke multiple time goes, "Down by the smoke. R337 state cigarettes in the rocoxygen. R337 state with her if they are pherself. Further, R3 smoking on her own gone outside to obsher about her ability. During interview on assistant (NA)-K state several times during don't tell us about it was safe to smoke	ord was reviewed and lacked rehensive assessment to afe to smoke without rimine if any interventions sure her safety with ling while off campus. ated 11/11/16, identified R337 "Pt [patient] aware facility is a plan listed a goal for R337 to spiratory health complaints ons which included instructing its or family with her while ap lighter in safe area away 12/1/16, at 8:24 a.m. R337 in outside smoking that surveyor had observed her adding she goes out to as a day. R337 stated she attreet [Bass Lake Road]," to add she has her own lighter and om, but no longer uses and family will sometimes go oresent, but she often goes by 337 stated she felt safe in adding no staff had ever serve her smoke or talked with a to smoke on her own. 12/1/16, at 8:59 a.m. nursing ated R337 goes out to smoke on her own. 12/1/16, at 8:59 a.m. nursing ated R337 goes out to smoke on her own. 12/1/16, at 8:59 a.m. nursing ated R337 goes out to smoke on her own. 12/1/16, at 8:59 a.m. nursing ated R337 goes out to smoke on her own.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	1/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST THERESE HOME			S LAKE ROA E, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	registered nurse (Routside on her own suspected she was smells like smoke vRN-F stated R337 hadmitted to the nursher it was a non-smremoved. RN-F stated R34 had ever been assess unsupervised smoked be a good thing to cherself" potentially it to drop it or have a During interview on registered nurse (Rosmoking while in the and being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself out when shand being warned, right outside the frocherself outs	N)-F stated R337 goes at times adding staff smoking because she often when she comes back inside. The sing home, however staff told toking campus and it was atted she was unaware if R337 assed for her safety with the sing, however, added it would do because R337, "Could burn of she was smoking and were problem. 12/1/16, at 10:31 a.m. N)-D stated R337 had been a facility since her admission "Several times" about smoking and toors and not signing the goes outside consistently. The seessed for safety with her was a tobacco free campus, and she was safe to smoke the she was safe to smoke the she was safe to smoke the she could potentially start of the same she could potentially start of the same she could potentially start of the safety related to smoking. The safety related to smoking to ce Committee and complete	2 830				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
	(21) days.					
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/10/17
	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.					
	by: Based on observati review, the facility for comprehensive ass plan interventions for reviewed for pressuractual harm for this failed to consistently	ent is not met as evidenced ion, interview, and document ailed to conduct a sessment nor develop care or 1 of 3 residents (R125) are ulcers which resulted in a resident. The facility also y monitor a pressure ulcer for 68) reviewed for pressure		These orders have been reviewed be corrected	and will	
	identified R125 was admission Minimum	Record dated 8/16/16, s admitted on 8/16/16. The n Data Set (MDS) dated R125 as being at risk for				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00261	B. WING		12/01/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		.,
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	OLIMANA DV. OTA		PE, MN 5542			0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	(partial thickness lo shallow open ulcer without slough. Ma open/ruptured bliste also identified R125 assistance of two s Care Area Assessmidentified pressure condition, however, findings/trigger nor considerations related. The Braden Scale (pressure ulcer risk) R125 as a moderated Tissue Tolerance (trappropriate reposition identified R125 had coccyx that were coand the balance of The Admission Obs 8/16/16, identified to 0.2 centimeters (cm area and a 0.4 cm letthe coccyx ulcers. identified was that the Review of the physicial dentified wound cated times per week and cleanser and apply The Order Summan	didentified three, stage 2 ss of dermis presenting as a with a red-pink wound bed y also present as an intact or er) pressure ulcers. The MDS as needing extensive taff with bed mobility. The nent worksheet (CAA) ulcers as a triggering the CAA did not analyze the did it develop any care planted to pressure ulcers. Cassessment to identify dated 8/16/16, identified e risk for pressure sores. A cool used to determine oning needs) dated 8/16/16, idecumented open areas on overed with foam dressings buttock area skin was intact. Servations/Assessment dated wo stage 2 ulcers measuring by 0.2 cm on the coccyx oy 0.4 cm stage 2 area below The assessment also both heels were "mushy." It cian orders for 8/16/16, re to coccyx open areas 2 if PRN, cleanse with wound foam adhesive dressing.	2 900			
	twice a week and a with wound cleanse dressing PRN. The progress note dated	re to open area on coccyx s needed (PRN). Cleanse er, apply foam adhesive e nurse practitioner (NP) d 8/17/16, identified, "facility at pt [patient] has a wound on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	01/2016
	NAME OF PROVIDER OR SUPPLIER ST THERESE HOME 8000 BAS NEW HO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	her buttocks." The initial care plan pressure ulcer with to edema. The care interventions to prepressure ulcers of the not identify any considering and considering R125's stay. A hospice plan of care gland plan of care for this problem admission to the fact and nutritional deficition assess actual/potential starting 8/11/16, insight skin breakdown, RN methods to prevent care PRN starting 8 to open area on considering plan individual plan of care did not care plan individual plan of care did not Review of the week 8/16, 8/24, 8/31, 9/3 pressure area to comby 0.1 cm, stages mall stage 2 pressed ocumented - these Treatment plan: wo areas 2 times per work Cleanse with wound dressing. No other The documentation	a dated 8/16/16, identified site being the coccyx related e plan did not include any vent worsening of the current he coccyx. The care plan did cerns with the heels. In lacked evidence that the comprehensive care plan at the facility. The with a start date of skin integrity-impaired (start m 8/11/16, 5 days before cility) secondary to mobility sit. Interventions identified intial skin breakdown PRN truct on methods to prevent instruct caregiver on skin breakdown. Wound 3/11/16. Hydrocolloid dressing ccyx, pressure relief cushion in spice care plan was not he facility did not develop a ized to R125's needs. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/01	1/2016
	PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S' SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 14	2 900			
	address "mushy" ar treatment/interventi A hospice note from as being red, almost Dressing on right honot open. A hospic "staff reports coccy. However, this is condocumentation which pressure ulcers. A nursing note date wound team was as coccyx area. The tocm skin tear to the (posterior superior is as a hematoma with at noon to 3 and at 2.2 cm by 4.5 cm. was not related to p	n 9/8/16, identified coccyx area at purple. Not opened. eel with left heel being red and e note dated 9/9/16, identified, x area is closed and purple." inflicting to the weekly wound ch does address healing of the days of the days of the days of the sked to observe R125's eam observed a .7 cm by 1.1 left side over the PSIS liac spine) with what appeared in purple bruising underneath 5 o'clock. Redness measured The wound team felt that area pressure but more of friction on				
	on right heel and the admission. Intervention and dressing to heel indicated NP was the for coccyx wound. Ouse heel manager at hours, right heel had new order for dress practitioner (NP) idefor concerns of skirn nurse. A physical expression of the properties of th	/13/16, indicated intact blister at heels were mushy upon itions to include, heel manager el. A follow up note on 9/13/16, here with resident. New order Order included left heel boggy, and float, reposition every 2 intact blister, left buttocks				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00261	B. WING		12/01/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	12/0	1/2010
			S LAKE RO			
STIFE	RESE HOME	NEW HOP	E, MN 5542	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 15		2 900			
	granulation tissue, covered wound not by 1 cm. as well as on the coccyx meas. The assessment pl follows: 1. Pressure ulcer or Patient had a foam dressing removed a the heel. The facility concern and unsure Orders for wound or cleanser, pat dry, a on bath day and PF dislodgement. Hee	r (composed of necrotic muscle, fat, tendon or skin) ed on the left buttocks 2.5 cm small clean open area noted suring 0.2 cm by 0.2 cm. an from the NP was as f heel, right stage 2: dressing on right heel. When an intact blister was noted on ty nurse was unaware of this e of when it was noted. are were cleanse with wound pply foam dressing, change RN if drainage or els to be floated while in bed on while up in wheelchair.				
	ulcer is completely is light colored soft (black or brown or of Upon examination awas noted on the lewas unaware of this occurred. No dress Orders for wound cleanser, padressing and changed drainage and dislocevery 2 hours both and pressure reduction wheelchair. 3. Pressure ulcer, of This was a known pressure and the pressure reduction of the pressure ulcer, of the pressure ulcer, of the pressure ulcer, of the pressure ulcer, or th	e loss in which the base of the covered by slough (tissue that and moist) and/or eschar dead tissue) in the wound bed. a 100% eschar covered wound of the buttocks. The facility nurse is sore and unsure of when this sing was noted on the sore. are were to cleanse with at dry, apply calcium alginate ge on bath day and PRN for eigement, turn and reposition while in bed an in wheelchair etion mattress and cushion for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
	PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S' SS LAKE ROA PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	wound was identified to measure due to to Orders included howevery shift and PRN hours both while in pressure reduction wheelchair. The weekly wound identified a weekly identified the follow blister to the right stage 2 pressure at the to coccyx, and anot 2 pressure ulcer to eschar - unstageab in which the base of covered by slough, R125 was seen by an ochanges were made weekloped by the stage 2 pressure ulcer to eschar - unstageab in which the base of covered by slough, R125 was seen by an ochanges were made weekloped and to prevent the wors ulcers until 9/13/16. During interview on director of nursing (have been intervent admission and ongothey should look at correct one for preserepositioning, cushi	In das having depth but unable he small size of the wound. Use barrier cream with zinc I, turn and reposition every 2 bed and in wheelchair and mattress and cushion for documentation on 9/14/16, wound documentation and ing: heel first identified on 9/13/16. Ulcer 0.2 cm by 0.2 cm by 0.0 her to coccyx identified stage 2 cm by 0.2 cm by 0.0, left side of buttocks, 100% le pressure ulcer (tissue loss if the ulcer is completely and/or eschar. The physician on 9/16/16, and hade to the treatment plan that he NP on 9/13/16. 11/30/16, at 12:35 p.m. N)-B verified no care plan had dinterventions implemented ening of R125's pressure	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	01/2016
	PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	looked at weekly to updated as needed pressure ulcers wornot been implement worsening. During interview on nurse practitioner (I admitted with a knowled. She stated the stage 2 pressure ulters was deferred. I about R125's heels other pressure ulcerstated that she was 9/13/16, per the wortime she observed a heel (it was a blister the buttocks as well coccyx. She stated unstageable area a with a dressing. She unaware of both of 13th of September areas, and verified worsened. The facility policy Protocol 1. Pressure: a. Determine cause. Determine cause. Redistribute proff-load, if indicated c. Implement preaccordance with research.	see if they were effective and. He verified that R125's resend and interventions had ted to prevent them from 12/12/16, at 2:30 p.m. the NP)-A stated R125 was wn stage 2 coccyx pressure nat she did not visualize the cer on the day of admission, NP-A stated she did not know being mushy or about the ron R125's buttocks. She requested to look at R125 on and team. She stated at this a stage 2 pressure ulcer to the r) and an unstageable ulcer to I as the stage 2 ulcer to the there was no dressing on the not the heel had been covered the stated the facility nurse was these areas. She stated the was the first she observed the the heel and buttocks had ressure Ulcer Treatment of the individual of the following are of pressure and relieve; ressure and interventions to	2 900			

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PRINTED: 12/27/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00261 12/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 18 2 900 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.

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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

"nonblanchable redness to her R (right) buttock."

(CAA), dated 11/23/16, identified a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
ST THER	ESE HOME		S LAKE RO			
040 15	CLIMMA DV CTA		E, MN 5542		NI .	()(5)
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 19		2 900			
	The CAA indicated R68's right buttock was being monitored daily for changes.					
	indicated the follow - On 11/13/16, at 2: documentation ider Later that day, at 9: noted on the right b (centimeters) x (by) - On 11/14/16, at 3: identified as "fragile facility's wound tear stage 1 pressure ul - On 11/22/16, at 12 was observed with maceration to wour were documented On 11/24/16, at 11 was observed with 1 cm x 0.8 cm. The wound bed On 11/25/16, 11/2 buttock dressing was wound bed was not - On 11/30/16, at 3: dressing was changimproving," however x 2.5 cm x 0.3 cm the wound as "In between x 2.5 cm x 0.3 cm the pressure ulcer. R68's first Weekly Nassessment, dated pressure ulcer was The assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer was the assessment inchad increased to a second control of the pressure ulcer.	32 p.m. R68's admission atified redness to the buttocks. 53 p.m. a scabbed area was uttock measuring 1.5 cm 0.6 cm. 0.6 cm. 0.7 a.m. R68's buttocks was but intact" indicating the m would evaluate and treat the cer. 2:54 p.m. R68's right buttock a "superficial open area of ad edges." No measurements :28 a.m. R68's right buttock a small open area measuring note did not describe the 6/16, and 11/27/16, R68's right as changed, however, the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00261	B. WING	B. WING		12/01/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST THEF	RESE HOME		S LAKE RO				
			PE, MN 5542				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 20	2 900				
	granulation (healthy (necrotic tissue that addition, the assess developed a new still left buttock measur deep consisting of 25% slough. Both a with R68's progress staging of R68's pro						
	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.						
	LPN-B stated the ri middle (the pressur deeper than the red	11/30/16, at 11:56 a.m. ght buttock had an area in the e ulcer) that looked slightly dened superficial skin around t it all together" measuring it					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
	NAME OF PROVIDER OR SUPPLIER ST THERESE HOME 8000 BAS NEW HO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	all as one. During observation registered nurse (R and measured right cm x 1.5 cm x 0.4 cpressure ulcer was slough. In addition, the pressure was rewould still be consisted R68's left buredness and was in During interview on stated R68's pressure on 11/22/16 by the opened and progresstated the right butt measurements for twere incorrect, furth should be measure periwound. RN-C sipressure ulcer on the wound assessmincorrect. During interview on stated the floor nurs monitoring pressure weekly with measure monitoring should chow the wound bed changes. RN-D statemeasuring pressure RN-D reported wou assessments, and raccurate to ensure and to prevent infections.	on 12/1/16, at 9:31 a.m. N)-C performed wound cares buttock pressure ulcer 1.1 am deep. RN-C stated the superficial and did not contain RN-C stated the skin around eddened, dry, and peeling, but dered the periwound. RN-C ttock contained blanchable tact. 12/1/16, at 11:01 a.m. RN-C are ulcer had been observed wound team when it had used to a stage 2. RN-C ocks was healing and the the previous day, on 11/30/16, her stating the wound bed d separately from the tated R68 had never had a me left buttocks, further stating then the from 11/28/16 was 12/1/16, at 11:47 a.m. RN-D uses were responsible for e ulcers daily and charting rements. RN-D stated the daily consist of the drainage, odors, and if there are any ted inconsistencies in e ulcers was an ongoing issue. In disconsistencies in the right treatment is ordered				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		DATE SURVEY COMPLETED	
		00261	B. WING		12/01/2016		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	/ •		
ST THER	ESE HOME		S LAKE RO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	"Document the assi Weekly Wound Doc directed staff to per pressure ulcers, wh ulcer if no dressing dressing, status of s presence of possible SUGGESTED MET director of nursing (the pressure ulcer p could provide educat the importance of a	e managers or designee to essment status weekly on the cumentation" and specifically form daily monitoring of hich included "Evaluation of the present, evaluation of surrounding area, and	2 900				
	The DON could developed staff to monitor that implemented. The cassurance committed pressure ulcers to each the appropriate care	velop a system for the nursing interventions are quality assessment and ee could do random audits of ensure residents are receiving					
2 920	Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			1/10/17	
	This MN Requirement	ent is not met as evidenced					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMPI		
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 23	2 920			
	review the facility fa for 3 of 5 residents unable to perform g	on, interview and document iled to provide grooming cares (R202, R229, R44) who were rooming and personal ensive staff assistance.		These orders have been reviewed be corrected	l and will	
	Findings include:					
	11/8/16, identified F cognition. The MDS	nimum Data Set (MDS) dated 8202 had moderate impaired 6 indicated R202 required se of staff with grooming.				
	needed assist with a conditions including decreased mobility.	ast revised for on 6/21/16, identified that R202 grooming/hygiene related to impaired cognition and The care plan further dementia/memory loss.				
	11/29/16, at 1:16 p. have long facial hai The facial hair was conversation. R202	ration in the lounge area on m. R202 was observed to r on her chin and upper lip. easy to visualize during was also observed to have nails that had black and brown ils.				
	R202 was observed	on 11/29/16, at 6:45 p.m. I lying in bed after evening npleted. R202 still had long long nails.				
	R202 was observed remained very dirty	on 11/30/16, at 8:16 a.m. If in the dining room. Nails underneath and also had a steed on top of several nails emained.				
	On 11/30/16, at 1:1	1 p.m. R 202 was observed in				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
ST THEF	RESE HOME		S LAKE ROAPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 24	2 920			
		ing with her daughter. have long facial hair and long n and black debris				
	family member (F)-concern to the facili mother's appearant occasions she had on her mother's har also stated that her and dirty long finger with the facility but in occurrence. The da	11/30/16, at 1:11 p.m. R202's A stated she had expressed ity previously about her ce. She stated on previous noted bowel movement (BM) ands and under her nails. She mother having long facial hair mails had been addressed to continued to be a common aughter became weepy and was a very classy lady and led by this."				
	continued to have loblack/brown substa	on 12/1/16, at 9:26 a.m. R202 ong facial hair and nce under nails. A sour odor ming from R202's hands.				
	assistant (NA)-B sta	12/1/16, at 9:44 a.m. nursing ated residents are shaved with d nails are done with bathing.				
	stated residents ge	12/1/16, at 9:50 a.m. NA-C t shaved with their cares if Is done with baths and as				
	registered nurse (R long facial hair on F have been shaved that nails are norma also be done as ne	12/1/16, at 12:55 p.m. N)-B verified the presence of R202. She stated R202 should with cares. She also stated ally done with baths but should eded. She verified R202's dirty and should have been ed with cares.				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER ST THERESE HOME B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	ON IDENTIFICATION NUMBER: A. BUIL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	00261 B. WING		
ST THERESE HOME 8000 BASS LAKE ROAD NEW HOPE, MN 55428	00201	NAME OF DE	
NEW HOPE, MN 55428	8000 BASS LAKE		
	NEW HOPE, MN	SI IHEKE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS) (EACH CORRECTION SHOULD BE COMPRESS PLAN OF CORRECTION (X COMPRESS) COMPRESS PREFIX (EACH CORRECTION SHOULD BE COMPRESS) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DEFICIENCY MUST BE PRECEDED BY FULL PREF	PREFIX	
2 920 Continued From page 25 2 920	From page 25 2 920	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. In eed 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	mission MDS dated 8/29/16, included of dementia and anxiety disorder. The er indicated R229 had severe cognitive it, and required extensive assistance to personal hygiene. The Care Area ant (CAA) for ADLs, dated 8/29/16, R229 required assistance with all ADLs by Body Dementia and Parkinsonian a		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETE	(X3) DATE SURVEY COMPLETED	
00261 B. WING 12/01/20	/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	2010	
ST THERESE HOME 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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," 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 wheelichair in the commons area. R44 had visibly long fingernails on all		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 27	2 920			
		ng," and he would like them ut, "Not too many people" help				
	1:18 p.m. and 11/30	observations on 11/29/16, at 0/16, at 1:45 p.m. R44 ong fingernails on both of his				
	required extensive complete grooming when it comes to cl	ted 11/26/16, identified R44 assistance from staff to tasks adding, "I am scared ipping my nails so I like it if n it and explain to me what you				
	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."					
	stated she observe were, "A little bit lon	11/30/16, at 2:00 p.m. LPN-A d R44's fingernails and they g," and the nurse assigned to a day should have clipped				
	11/2016, identified a finger/toe nails wee needed]." The recond had been complete observed with long 11/26/16.	dministration Record dated an intervention, "Trim kly with bath and PRN [as ord identified trimming of nails d two days prior to being fingernails by the surveyor on				
	A facility Resident 0	Care: Grooming policy dated				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:				(X3) DATE S COMPL		
		00261	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 28	2 920			
	with grooming AM a needs." Further, the bathing, nail care, a SUGGESTED MET	HOD OF CORRECTION: The				
	develop, review, and procedures to ensure preferences with action of nurseducate all appropries procedures. The director of the director of nurseducate all appropries are the director of the	DON) or designee could d/or revise policies and re all residents personal tivities of daily living are met. ing (DON) or designee could fate staff on the policies and ector of nursing (DON) or elop monitoring systems to inpliance.				
	TIME PERIOD FOF (21) Days	R CORRECTION: Twenty-one				
21385	MN Rule 4658.0800 Staff assistance	Subp. 3 Infection Control;	21385			1/10/17
	Personnel must be infection control pro the residents and no	stance with infection control. assigned to assist with the gram, based on the needs of ursing home, to implement cedures of the infection				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview, and document ailed to ensure proper hand ed for 1 of 1 residents (R68) und cares.		These orders have been reviewed be corrected	and will	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/01	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 29	21385			
	11/20/16, indicated	nimum Data Set (MDS) dated the presence of a pressure related to pressure.)				
	licensed practical n gloves on her hand prior to donning. Sh gloves over the alre removed R68's soil the soiled dressing, small amount of sel drainage from R68' soiled dressing, wa R68's wound then r of gloves. LPN-B pr dressing while wear potentially contamir new dressing over I her hands should h before donning glov between changing to	on 11/30/16, at 9:40 a.m. urse (LPN)-placed a pair of and did not wash her hands the then placed another pair of rady gloved hands. LPN-B and dressing. After removing LPN-B stated it contained a rous (pale yellow color) is wound. LPN-B discarded the shed, dried, and measured amoved one of the two pairs roceeded to open the new ring the second pair of th				
	registered nurse (R removed and chang dressings. RN-D fur facility's policy to do education on prope care in orientation a During interview on stated "The use of appropriate" and was	12/1/16, at 11:47 p.m. N)-D stated gloves should be ged in between dirty and clean of the stated it was not the buble glove and staff received or hand hygiene during wound and annually. 12/1/16, at 2:46 p.m. RN-E double gloving is not as not taught by the facility. the observation provided an				

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Minnesota Department of Health STATE FORM

The facility policy Infection Control: Use of Gloves

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	dated 1/05, directed between tasks on the with material that monocontration of midirected staff to remon-contaminated in the facility policy Indated 2/10, directed hygiene prior to appropriate prior to appropriate the designee could regarding infection her designee could procedures and devensure compliance	I staff to change gloves in ne same resident after Contact ay contain a high croorganisms. It further nove gloves before touching	21385			
21665	A nursing home must functional, comfortate environment, allowing personal belonging. This MN Requirements by: Based on observation review, the facility fakitchen environment production kitchens	O Physical Environment ust provide a safe, clean, able, and homelike physical ng the resident to use is to the extent possible. The possible of the extent poss	21665	These orders have been reviewed be corrected	and will	1/10/17

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 31	21665			
	finding include:					
	11/28/16, at 10:32 a were observed on a area. One mounted toward the clean sid three tier metal rolli observation, two rac serving utensils and of the dishwasher of fan. When turned owere covered with extending from the During interview on stated the thick gray and the fan "Needs maintenance took at them once a month missed." DM-A furth dishes were stored	of the residence kitchen on a.m. two wall mounted fans and blowing in the dishwashing fan was observed blowing de of the dish area where a ng cart stood. During cks of clean dishes, containing d clear plastic jugs, came out on a conveyor belt toward the ff, the wire rings of the fan nanging thick gray fuzz middle to the back of the fan. 11/28/16, at 10:32 a.m. DM-A y substance "Looks like fuzz" to be cleaned." DM-A stated apart the fans and cleaned but that one "Must've been ner stated the cleaned wet on the the metal cart in the en put away at night.				
	o .	on 12/1/16, at 10:14 a.m. the leaned without any gray fuzz.				
	During interview on stated that particula others and couldn't DM-A states "I would it only got half done clean the fan. DM-A expect staff to reme	12/1/16, at 10:19 a.m. DM-A or fan was different than the be taken apart to be cleaned. Idn't say it got missed, I'd say of a staff had to climb up to a further stated she would be or that fan needs to be when completing the task.				
	undated, directed m guards monthly; ho	led Cleaning of Wall Fans, naintenance to remove the fan wever, the policy directed the off dust and dirt build up and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 32	21665			
		s. The policy further directed event dust being moved onto ce 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 (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			1/10/17
	residents have the courtesy and respe-	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review, the facility fa grooming to promot (R202) reviewed for grooming.	ent is not met as evidenced on, interview, and document ailed to provide personal te dignity for 1 of 3 residents r activities of daily living and		These orders have been reviewed be corrected	and will	
	Findings include:					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00261	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		SS LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	R202's quarterly Mi 11/8/16, identified F cognition. The MDS extensive assistance R202's care plan, la grooming/hygiene or needed assist with conditions including decreased mobility, identified R202 had During initial observed 11/29/16, at 1:16 puhave long facial hair was conversation. R202 long, jagged fingerredebris under the nature During observation R202 was observed cares had been confacial hair and dirty During observation R202 was observed cares had been confacial hair and dirty During observation R202 was observed cares had been confacial hair and dirty During observation R202 was observed cares had been confacial hair and dirty During observation R202 constant of the facial hair results of the facial hair results with dark brown underneath. During interview on Durin	nimum Data Set (MDS) dated R202 had moderate impaired indicated R202 required are of staff with grooming. Ast revised for on 6/21/16, identified that R202 grooming/hygiene related to impaired cognition and The care plan further dementia/memory loss. Action in the lounge area on m. R202 was observed to ron her chin and upper lip. easy to visualize during was also observed to have nails that had black and brown ils. On 11/29/16, at 6:45 p.m. If lying in bed after evening inpleted. R202 still had long long nails. On 11/30/16, at 8:16 a.m. If in the dining room. Nails underneath and also had a oted on top of several nails emained. I p.m. R 202 was observed in ing with her daughter. have long facial hair and long an and black debris.	21805			
		A stated she had expressed ty previously about her				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	1/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ST THE	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	mother's appearance occasions she had on her mother's har also stated that her and dirty long finge with the facility but occurrence. The dastated, "My mother she would be appa." During observation continued to have leblack/brown substated was noted to be concurrenced in the property of the property	ce. She stated on previous noted bowel movement (BM) nds and under her nails. She mother having long facial hair rnails had been addressed it continued to be a common aughter became weepy and was a very classy lady and lled by this." on 12/1/16, at 9:26 a.m. R202	21805			

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12/01/2016

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___

NAME OF PROVIDER OR SUPPLIER

00261

STREET ADDRESS, CITY, STATE, ZIP CODE

ST THERESE HOME

8000 BASS LAKE ROAD

ST THER		OPE, MN 55428	3	
(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
21805	Continued From page 35	21805		
	complete audits to ensure compliance.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	9		

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		
		00261	B. WING		12/01/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
ST THERE	ESE HOME		S LAKE ROAD E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	DRRECTION ORDER			
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires contended requires contended and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that a	earing on any assessments con-compliance with these a written request is made to 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesot	a Department of Health	<u>n</u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00261	B. WING		12/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
			S LAKE ROAD	,	
ST THERE	SE HOME		E, MN 55428		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE
			-	DEI IOIENOT)	
2 000	Continued From page	e 1	2 000		
	Department of Health	orders being submitted to			
		though no plan of correction			
	-	e Statutes/Rules, please			
	•	cted" in the box available for			
	text. You must then in	ndicate in the electronic			
		ss, under the heading			
	T	date your orders will be			
	•	ctronically submitting to the			
	Minnesota Departmen				
		2016, through December 1st nis Department's staff,			
		vider and the following			
	•	issued. Please indicate in			
		of correction that you have			
		s, and identify the date when			
	they will be completed	d.			
		nt of Health is documenting			
		Correction Orders using			
	federal software. Tag				
	Nursing Homes. The	a state statutes/rules for			
	•	column entitled "ID Prefix			
		te/rule out of compliance is			
		y Statement of Deficiencies"			
		the "To Comply" portion of			
	the correction order.	This column also includes			
		e in violation of the state			
		ment, "This Rule is not met			
		owing the surveyors findings			
		ethod of Correction and			
	Time period for Corre	CUOII.			
	An investigation of co	mplaint H5518070 was			
		not to be substantiated.			
	,				
	PLEASE DISREGAR	D THE HEADING OF THE			
	FOURTH COLUMN V	WHICH STATES,			
		OF CORRECTION." THIS			

Minnesota Department of Health

APPLIES TO FEDERAL DEFICIENCIES ONLY.

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Minnesota Department of Health

MILLIOSOL	a Department of Health	1				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		00261	B. WING		12/0	1/2016
NAME OF D		OTDEET ADI	NDEOD OITY OTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME	8000 BAS	S LAKE ROAD			
• • • • • • • • • • • • • • • • • • • •		NEW HOP	E, MN 55428			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
2 000	Continued From page	. 2	2 000			
2 000	Continued From page	; 2	2 000			
	THIS WILL APPEAR	ON EACH PAGE.				
	THERE IS NO REQU	IREMENT TO SUBMIT A				
		ION FOR VIOLATIONS OF				
	MINNESOTA STATE	STATUTES/RULES.				
2 540	MN Rule 4658.0400 S	Subp. 1 & 2 Comprehensive	2 540			
	Resident Assessment	t				
	Subpart 1. Assessme	ent. A nursing home must				
		sive assessment of each				
		ch describes the resident's				
		daily life functions and				
		ts in functional capacity. A				
	_	conducted according to				
	1	section 148.171, subdivision				
		eart of the comprehensive				
	resident assessment.	The results of the				
	comprehensive reside	ent assessment must be				
	used to develop, revie	ew, and revise the resident's				
	comprehensive plan	of care as defined in part				
	4658.0405.	·				
	Subp. 2. Information	on gathered. The				
	comprehensive reside					
	include at least the fo					
		ned conditions and prior				
	·	ica conditions and prior				
	medical history;					
	B. medical status					
		nental functional status;				
		hysical impairments;				
		us and requirements;				
	· ·	ents or procedures;				
	G. mental and ps	ychosocial status;				
	H. discharge pote	ential;				
	dental condition					
	J. activities poten					
	K. rehabilitation p					
	L. cognitive statu					
	_					
	M. drug therapy; a					
	N. resident prefer	rences.				

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		00261	B. WING		12/0	1/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		S LAKE ROAD PE, MN 55428			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
2 540	Continued From page	2 3	2 540			
	by: Based on interview ar facility failed to compresidents skin care no (R125) who was review Findings include: R125's admission Mirassessment dated 8/2 having three stage 2 dermis presenting as red-pink wound bed was present as an intactor blister) pressure ulcers admission. The admifailed to include any (CAA) related to the idissues/pressure ulcers (assessment of R125's (assessment to identified R1 pressure sores. A Tis 8/16/16, identified R1 pressure sores. A Tis 8/16/16, identified resareas on coccyx that dressings and the bal was intact. The Admi Observations/Assessidentified two stage 2 0.2 centimeters (cm) area and a 0.4 cm by the coccyx ulcers. The both heels were "mustices areas on interview of the coccyx ulcers. The both heels were "mustices area and a continuation of the coccyx ulcers. The both heels were "mustices area area."	nimum Data Set (MDS) 23/16, identified R125 as (partial thickness loss of a shallow open ulcer with a vithout slough. May also r open/ruptured s that were present upon ssion MDS assessment Care Area Assessment dentified skin s. d lacked any comprehensive s skin. A Braden Scale fly pressure ulcer risk) dated 25 as a moderate risk for ssue Tolerance dated ident had documented open were covered with foam ance of buttock area skin ssion ment dated 8/16/16, pressure ulcers measuring by 0.2 cm on the coccyx 0.4 cm stage 2 area below e assessment also identified shy".				
		Report dated 8/17/16, to open area on coccyx				

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_	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI	
		00261	B. WING		12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE		
ST THERE	SE HOME		S LAKE ROAD E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 540	with wound cleanser, dressing PRN. The material progress note dated 8 nurses reported that pher buttocks that she laying back down in buttocks tha	needed (PRN). Cleanse apply foam adhesive surse practitioner (NP) 8/17/16, identified "facility of [patient] has a wound on will be evaluating once pt is sed." 2/1/16, at 1:35 p.m. the rified no comprehensive in completed and that the en done. OD FOR CORRECTION: g (DON) and/or designee and provide education for staff of an individualized ent assessment including its for admission, annual es. The Quality Assessment occumittee could do	2 540			
	•	nprehensive plan of care ersonnel involved in the				
	This MN Requiremen by:	t is not met as evidenced				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.1.12 1 27.11 1			A. BUILDING: _		00 22.25
		00261	B. WING		12/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ST THERE	ESE HOME		S LAKE ROAD E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
2 565	review, the facility fail plan for 1 of 5 resider activities of daily living dependent upon staff Findings include: R229's diagnoses as Minimum Data Set da dementia and anxiety Assessment for ADLs R229 required assistatewy Body Dementia R229's care plan, rev R229's abilities with grelated to R229's diagdirected: "I may be a Hand me my razor and complete. I need you have my attention whilf I am unable to compleme. I need to be share During observation or R229 was ambulating the first floor. R229 papproximately 1/8 incincluded longer stubb	interview, and document ed to implement the care ats (R229) reviewed for g (ADLs), who was for hygiene. indicated on the admission ated 8/29/16, included disorder. The Care Area, dated 8/29/16, indicated ance with all ADLs due to and Parkinsonian tremor. ised 11/23/16, identified rooming were variable, phoses. The care plan able to complete my shaving. In digive me cues to to stand on my left side and en you are giving me cues. Solete, I need staff to shave aved every morning." in 11/28/16, at 3:45 p.m. In the dining room area on resented with facial hair, in growth, which also les under his chin. On in. while seated at a table in	2 565		
	was observed lying as still present and unsh During observation or 7:49 a.m. nursing ass R229 with routine mo	Later at 7:22 p.m., R229 sleep in bed, with facial hairs aven. n 11/30/16, from 7:36 a.m. to istant (NA)-D provided rning cares in his room. with toileting, washing,			

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428 (X4) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1 2 565 Continued From page 6 2 565		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
ST THERESE HOME SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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," 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	00261		B. WING		12/0	1/2016		
ST THERESE HOME NEW HOPE, MN 55428	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 not offered shaving this morning during his cares. NA-D said," just forgot it." NA-D stated R229 was normally 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	ST THERE	ESE HOME						
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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 meansto assess		R229 returned to bed was he offered assist provision of cares. Runtil NA-D assisted R breakfast at 9:12 a.m During interview on 1 assistant (NA)-D said unshaven, and ackno offered shaving this m NA-D said,"I just forgowas normally shaved should be shaved evenissed." During an interview of licensed practical nursexpect and trust the ashave R229 every da unsuccessful, to "let m R229 had behaviors at that interfered with con R229 could be resisting we should always, ald document refusals of During interview on 1 director of nursing (Dothe aides to follow the residents as needed. expected the nurses if ensure routine cares of Planning, dated Feb 22 planning, dated Feb 23	R229 was not shaved, nor ance to shave, during the 229 remained in his room 229 to the dining room for, still unshaven. 1/30/16, at 1:46 p.m. nursing R229 was currently wledged R229 was not norning during his cares. of it." NA-D stated R229 every day. NA-D said R229 eryday, "but [R229] just got if they were me know." LPN-C said she would aides would at least offer to y, and if they were me know." LPN-C said and involuntary movements impleting ADLs, and that we to cares. She also stated ways" keep trying, and care. 2/1/16, at 1:07 p.m. the ON) said he would expect eir care guide and shave The DON also stated he in charge to monitor staff to were completed. dent Assessment and Care 2014, indicated as its					

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Minnesota Department of Health

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	00261	B. WING		12/01/2016
		DDDECC CITY CTA	FF 710 000F	12/01/2010
ROVIDER OR SUPPLIER		, ,	TE, ZIP CODE	
SE HOME				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
Continued From page	: 7	2 565		
director of nursing (Do review or revise polici staff regarding care polici Quality Assessment a committee could do ra compliance.	ON) and/or designee could es, provide education for lan implementation. The and Assurance (QAA) andom audits to ensure			
MN Rule 4658.0520 S		2 830		
receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as powritten order from the resident must remain	and treatment, personal and upervision based on preferences as identified in sident assessment and ibed in parts 4658.0400 and phome resident must be out ssible unless there is a attending physician that the in bed or the resident			
by: Based on observation review, the facility fail assess safety with sm (R337) identified to be the facility.	i, interview and document ed to comprehensively noking for 1 of 1 residents			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETT) Continued From page SUGGESTED METHOR director of nursing (Do review or revise polici staff regarding care polici staff	DESCRIPTION NUMBER: 00261 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 8000 BASS LAKE ROAD NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 2 565 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. 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.	DENTIFICATION NUMBER: DOZ61 B. WING

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		I ' '	E SURVEY PLETED
		00261	B. WING		12	2/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ST THERE	ESE HOME		ASS LAKE ROAD OPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	e 8	2 830			
	R337's admission Mir dated 11/16/16, identicognition.	nimum Data Set (MDS) ified R337 had intact				
	dated 11/22/16, identi the transitional care u identified several diag "Tobacco use disorde	rare Follow-Up Visit note ified R337 was residing in unit at the facility. The note gnoses which included, er," with further dictation staff report that patient to smoke."				
	was seated on her ele from the street to the the facility. R337 was	g observation on 12/1/16, at 7:55 a.m. R337 seated on her electric scooter coming up the street to the main outside entrance to icility. R337 was dressed in a light sweater and no oxygen in place.				
	receptionist (RCP)-A smoke and has to go	12/1/16, at 7:58 a.m. the stated R337 goes outside to down by, "Bass Lake was not allowed to smoke				
	entries: - On 11/9/16, "she [until she could go out - On 11/10/16, "spo risks of smoking and using oxygenmade - On 11/16/16, "resi went outside" - On 11/29/16, "spo regarding smoking ou she [R337] is aware of	R337] refused to eat supper side and have a cigarette." ke to resident about the using butane lighter while promise not to smoke." dent able to wheel self and ke with resident on this date utside on campus stated of this and that she is electric scooter down to Bass				
		Writer stated that we do				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
00261 B. WING 12		12/0	1/2016			
	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ST THERE	ESE HOME	NEW HOPI	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 830	Continued From page	9	2 830			
	any identified compreensure R337 was saf supervision, to determ were required to ensuunsupervised smokin R337's care plan date was a smoker and, "Fnon-smoking." The phave decreased respiand listed intervention R337 to have friends smoking and to keep from oxygen tanks. During interview on 1 stated she had been morning when the suicoming inside. She as smoke multiple times goes, "Down by the smoke. R337 stated cigarettes in the room oxygen. R337 stated with her if they are properly for the same and th	nine if any interventions are her safety with g while off campus. 2d 11/11/16, identified R337 Pt [patient] aware facility is alan listed a goal for R337 to irratory health complaints as which included instructing or family with her while lighter in safe area away 2/1/16, at 8:24 a.m. R337 outside smoking that reveyor had observed her dding she goes out to a day. R337 stated she treet [Bass Lake Road]," to she has her own lighter and an, but no longer uses family will sometimes go esent, but she often goes by 7 stated she felt safe adding no staff had ever reve her smoke or talked with o smoke on her own. 2/1/16, at 8:59 a.m. nursing and R337 goes out to smoke oner shift by herself, "She NA-K stated she felt R337 in her own because she				
	could dress herself, "I					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE S	
AND PLAN	O CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	.L 1 E <i>U</i>
		00261	B. WING		12/0	01/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		S LAKE ROAD			
			PE, MN 55428			I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From page	± 10	2 830			
2 830	registered nurse (RN) outside on her own at suspected she was sr smells like smoke who RN-F stated R337 har admitted to the nursin her it was a non-smooremoved. RN-F stated had ever been assess unsupervised smoking be a good thing to do herself" potentially if sto drop it or have a proper department of the proper of the property of the proper of the	arimes adding staff moking because she often en she comes back inside. d a lighter when she g home, however staff told king campus and it was d she was unaware if R337 sed for her safety with g, however, added it would because R337, "Could burn she was smoking and were oblem. 2/1/16, at 10:31 a.m. a-D stated R337 had been facility since her admission everal times" about smoking doors and not signing goes outside consistently. d never been essed for safety with her as a tobacco free campus, as a tobacco free campus, be she could potentially start Further, RN-D stated the smoking safety policy as it OD OF CORRECTION: g (DON) or designee could itor to ensure all residents fety related to smoking. The ll staff on these systems. e could report the findings to be committee and complete	2 830			
	audits to ensure comp					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		00261	B. WING		12	2/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ST THERE	ESE HOME		ASS LAKE ROAD OPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page	2 11	2 830			
	(21) days.					
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900			
	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that:	ent assessment, the director ust coordinate the				
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical				
	receives necessary t	o has pressure sores reatment and services to vent infection, and prevent oping.				
	by: Based on observation review, the facility fail comprehensive assest plan interventions for reviewed for pressure actual harm for this refailed to consistently in the second	t is not met as evidenced n, interview, and document ed to conduct a ssment nor develop care 1 of 3 residents (R125) e ulcers which resulted in esident. The facility also monitor a pressure ulcer for o reviewed for pressure				
	admission Minimum [dmitted on 8/16/16. The				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED
			55.25.110.		
		00261	B. WING		12/01/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ST THERE	SE HOME		LAKE ROAD		
			E, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 900	Continued From page	2 12	2 900		
	pressure ulcers and id (partial thickness loss shallow open ulcer wi without slough. May open/ruptured blister) also identified R125 a assistance of two state Care Area Assessment identified pressure ulcerondition, however, the findings/trigger nor disconsiderations related. The Braden Scale (as pressure ulcer risk) dispressure ulcer risk) disconsiderations.	dentified three, stage 2 s of dermis presenting as a th a red-pink wound bed also present as an intact or pressure ulcers. The MDS as needing extensive if with bed mobility. The int worksheet (CAA) cers as a triggering he CAA did not analyze the did to pressure ulcers. ssessment to identify ated 8/16/16, identified risk for pressure sores. A			
	appropriate reposition identified R125 had do coccyx that were cover and the balance of but The Admission Obser 8/16/16, identified two 0.2 centimeters (cm) area and a 0.4 cm by the coccyx ulcers. The	ning needs) dated 8/16/16, ocumented open areas on ered with foam dressings attock area skin was intact. vations/Assessment dated o stage 2 ulcers measuring by 0.2 cm on the coccyx 0.4 cm stage 2 area below			
	times per week and F cleanser and apply for The Order Summary identified wound care twice a week and as with wound cleanser,	to coccyx open areas 2 PRN, cleanse with wound am adhesive dressing. Report dated 8/17/16, to open area on coccyx needed (PRN). Cleanse apply foam adhesive			
	progress note dated 8	ourse practitioner (NP) 3/17/16, identified, "facility ot [patient] has a wound on			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING: _			
		00261	B. WING		12	/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		8000 BAS	SS LAKE ROAD			
ST THERE	ESE HOME	NEW HO	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	Continued From page	2 13	2 900			
	her buttocks."					
	pressure ulcer with si to edema. The care pinterventions to preventions to prevention of identify any conceaddition, the record la facility developed a coduring R125's stay at A hospice plan of care 9/21/16, identified sk date for this problem admission to the faciliand nutritional deficit. assess actual/potentic starting 8/11/16, instrusting the skin breakdown, RN in methods to prevent sicare PRN starting 8/1 to open area on cocci wheelchair. The hospindividualized and the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active pressure and prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care prevention of the care plan individualized plan of care did not active prevention of the care plan individualized plan of care did not active prevention of the care plan individual prevention of the care plan individual plan of care did not active prevention of the care plan individual plan of care did not active prevention of the care plan individual plan of care did not active prevention of the care plan individual plan of care did not active prevention of the care plan individual plan of care did not active prevention of the care plan indi	acked evidence that the comprehensive care plan at the facility. The with a start date of in integrity-impaired (start 8/11/16, 5 days before sity) secondary to mobility Interventions identified all skin breakdown PRN act on methods to prevent instruct caregiver on kin breakdown. Wound 1/16. Hydrocolloid dressing yx, pressure relief cushion in pice care plan was not a facility did not develop a led to R125's needs. The ddress the heels.				
	8/16, 8/24, 8/31, 9/7,	wound documentation on 9/13 and 9/14/16, identified				
	1 -	cyx measuring 0.4 cm by 0.4 2. In addition, two other very				
	small stage 2 pressur					
		neasure 0.2 cm x 0.2 cm.				
		nd care to coccyx open				
		ek and as needed (PRN).				
		cleaner and apply adhesive				
	_	terventions were identified.				
	notified on 8/16/16 of	lentified the NP had been the pressure ulcers.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
		00261	B. WING		12	2/01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ST THERI	ESE HOME		SS LAKE ROAD DPE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From page	e 14	2 900			
	The weekly wound do address "mushy" area treatment/intervention	a to heels, nor any				
	as being red, almost pressing on right hee not open. A hospice "staff reports coccyx and However, this is conflict."	9/8/16, identified coccyx area purple. Not opened. If with left heel being red and note dated 9/9/16, identified, area is closed and purple." In icting to the weekly wound does address healing of the				
	wound team was ask coccyx area. The team skin tear to the left (posterior superior illians a hematoma with pat noon to 3 and at 5 2.2 cm by 4.5 cm. The	im observed a .7 cm by 1.1 If side over the PSIS ac spine) with what appeared ourple bruising underneath o'clock. Redness measured ne wound team felt that area essure but more of friction on				
	on right heel and that admission. Interventic and dressing to heel. indicated NP was the for coccyx wound. Or use heel manager an	3/16, indicated intact blister heels were mushy upon ons to include, heel manager A follow up note on 9/13/16, re with resident. New order der included left heel boggy, d float, reposition every 2 intact blister, left buttocks g change.				
	for concerns of skin in nurse. A physical exa	note from the nurse tified R125 was being seen ntegrity issues per the facility am identified an intact blister el measuring 2.2 cm by 2 cm				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00261	B. WING		12/0	1/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		LAKE ROAD			
			, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 900	Continued From page	2 15	2 900			
	and a 100% eschar (or granulation tissue, mu covered wound noted by 1 cm. as well as sr					
	The assessment plan follows:	from the NP was as				
	dressing removed an the heel. The facility concern and unsure of Orders for wound care cleanser, pat dry, app on bath day and PRN dislodgement. Heels	ressing on right heel. When intact blister was noted on nurse was unaware of this of when it was noted. e were cleanse with wound bly foam dressing, change				
	ulcer is completely co is light colored soft and (black or brown or dead Upon examination a 1 was noted on the left was unaware of this soccurred. No dressin Orders for wound care wound cleanser, pat of dressing and change drainage and dislodge every 2 hours both whand pressure reduction wheelchair.	oss in which the base of the overed by slough (tissue that and moist) and/or eschar ad tissue) in the wound bed. 100% eschar covered wound buttocks. The facility nurse sore and unsure of when this ag was noted on the sore. We were to cleanse with dry, apply calcium alginate on bath day and PRN for ement, turn and reposition hile in bed an in wheelchair on mattress and cushion for				
		ccyx, stage 2: essure ulcer. The ulcer was n no signs of infection. The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	` '		ONSTRUCTION	(X3) DATE COMF	SURVEY
	00261	B. WING		12	/01/2016
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
ST THERESE HOME		SS LAKE ROAD PE, MN 55428			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
to measure due to the Orders included housevery shift and PRN hours both while in the pressure reduction in wheelchair. The weekly wound of identified a weekly widentified the following blister to the right handler stage 2 pressure under 0.2 pressure ulcer 0.2 pressure ulcer 0.2 pressure ulcer to be eschar - unstageable in which the base of covered by slough, at R125 was seen by the no changes were may was developed by the R125 passed away. During interview on registered nurse (RN been developed and to prevent the worse ulcers until 9/13/16. During interview on director of nursing (I have been interventiad mission and ongo they should look at interventia director of nursing (I have should look at interventia direc	d as having depth but unable the small size of the wound. See barrier cream with zinc turn and reposition every 2 and and in wheelchair and mattress and cushion for documentation on 9/14/16, yound documentation and the first identified on 9/13/16. However, it is identified on 9/13/16. However, it is identified stage cm by 0.2 cm by 0.0, the first of buttocks, 100% the pressure ulcer (tissue loss the ulcer is completely and/or eschar. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the NP on 9/13/16. The physician on 9/16/16, and the treatment plan that the NP on 9/13/16. The physician on 9/16/16, and the treatment plan that the NP on 9/13/16.	2 900			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00261	B. WING		12/01/2016	3
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE		
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ST THERE	SE HOME		S LAKE ROAD			
		NEW HOI	PE, MN 55428			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
IAG		,	IAG	DEFICIENCY)		
			+			
2 900	Continued From page	e 17	2 900			
	looked at weekly to se	ee if they were effective and				
		He verified that R125's				
	I = -	ened and interventions had				
	· .	d to prevent them from				
	worsening.					
	During interview on 1	2/12/16, at 2:30 p.m. the				
	nurse practitioner (NF					
		n stage 2 coccyx pressure				
		t she did not visualize the				
		er on the day of admission,				
		P-A stated she did not know				
		eing mushy or about the				
		on R125's buttocks. She				
	•	equested to look at R125 on				
		nd team. She stated at this				
		stage 2 pressure ulcer to the				
		and an unstageable ulcer to				
		is the stage 2 ulcer to the				
		nere was no dressing on the				
	_	the heel had been covered				
	_	stated the facility nurse was				
	_	ese areas. She stated the				
		as the first she observed the				
	· ·	e heel and buttocks had				
	worsened.	e fleet and buttocks flad				
	worseneu.					
	The facility policy Pro	ssure Ulcer Treatment				
		6, identified the following				
	protocol:	o, identified the following				
	protocoi.					
	Stage I protocol					
	1. Pressure:					
		e of pressure and relieve;				
		ssure and interventions to				
	_ ·	ssure and interventions to				
	off-load, if indicated;	uro relieving device(s) is				
		sure-relieving device(s) in				
		dent's assessed needs;				
	d. Evaluate until re	uness is no longer				
	persistent;					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00261	B. WING	 	12/01/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ST THERE	SE HOME		S LAKE ROAD E, MN 55428		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 900	Continued From page	e 18	2 900		
	e. Persistent redne pressure has been re time it was applied an example: if resident h hours (120 minutes), re-evaluate site/area area has resolved); f. Notify physician, facility personnel and in medical record and g. Generate wound h. Obtain new treat 4. Immobility: a. Turn Schedule; b. Restorative nur walking, bed mobility) pain level with pain as Stage II Protocol	lieved for at least 3/4 of the and the redness remains (for lead been on side for two reposition/off load area and in 90 minutes to determine if family and appropriate document communication and assessment and complete. It is and resing (range of motion, and resing (range of motion, and research). It is and resing the property of the session of the			
	11/20/16, indicated no the presence of a Sta	mum Data Set (MDS), dated o cognitive impairment and ge 1 pressure ulcer (area of able redness) on admission.			
	(CAA), dated 11/23/1	Care Area Assessment 6, identified a ess to her R (right) buttock."			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD	<u>; </u>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD	3
8000 BASS LAKE ROAD	
8000 BASS LAKE ROAD	
ST THERESE HOME NEW HOPE, MN 55428	
	5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PLETE TE
2 900 Continued From page 19 2 900	
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	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE COMF	SURVEY
		00261	B. WING		12	/01/2016
	ROVIDER OR SUPPLIER	8000 BA	DDRESS, CITY, STATE SS LAKE ROAD PE, MN 55428	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 900	(necrotic tissue that daddition, the assessmedeveloped a new stagleft buttock measuring deep consisting of 75 25% slough. Both asswith R68's progress mataging of R68's pressure uto "Document weekly or identify a pressure uto measing to right butto soiled dressing, LPN-looked much better, the superficial, consisting contain slough, and we peeling skin. LPN-B mas 5.5 cm long x 2 cm to measure the length utoer on R68's lower lintact reddened skin operiwound). LPN-B diffrom open end to ope she measure the deposervation. In additional left buttock and stated intact. During interview on 1 LPN-B stated the right middle (the pressure deeper than the reddened skin open stated intact.	of 75% (percent) tissue and 25% slough oesn't promote healing). In the tindicated R68 had ge 2 pressure ulcer on the ge 1 cm x 0.5 cm x 0.2 cm % granulation tissue and the tissue and the previous sure ulcer. plan, undated, directed to ger to R buttock daily" and the status of ulcer." It did not the cer on the left buttock. 11/30/16, at 9:40 a.m. the cer (LPN)-B changed R68's tock. After removing the B stated R68's right buttock	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE S		
			A. BUILDING: _	A. BUILDING:		
		00261	B. WING		12/0	01/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		S LAKE ROAD E, MN 55428			
0/4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECT	ION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From page	21	2 900			
	all as one.					
	registered nurse (RN) and measured right b cm x 1.5 cm x 0.4 cm pressure ulcer was stated. In addition, R the pressure was redwould still be conside stated R68's left buttoredness and was inta. During interview on 1: stated R68's pressure on 11/22/16 by the woopened and progress stated the right buttor measurements for the were incorrect, further should be measured aperiwound. RN-C states.	2/1/16, at 11:01 a.m. RN-C e ulcer had been observed bund team when it had ed to a stage 2. RN-C cks was healing and the e previous day, on 11/30/16, r stating the wound bed separately from the ted R68 had never had a left buttocks, further stating				
	stated the floor nurse; monitoring pressure to weekly with measure; monitoring should cor- how the wound bed to changes. RN-D stated measuring pressure to RN-D reported wound assessments, and mo	ulcers was an ongoing issue. If measurements, Interior needed to be It is ordered				
	A facility policy entitle	ed Skin Care Protocol, dated				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND FLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
			D. MINO			
		00261	B. WING		12/01/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME	8000 BAS	SS LAKE ROAD			
		NEW HO	PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 900	Continued From page 22		2 900			
	"Document the asses Weekly Wound Docu directed staff to perfo	rrounding area, and				
	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.					
2 920	MN Rule 4658.0525 Subp. 6. Activities of	Subp. 6 B Rehab - ADLs daily living. Based on the ent assessment, a nursing	2 920			
	home must ensure th B. a resident who is activities of daily living	at: s unable to carry out g receives the necessary good nutrition, grooming,				
	This MN Requiremen by:	t is not met as evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		00261	B. WING		12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		E, MN 55428			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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2 920	Continued From page 23		2 920			
	review the facility faile					
	i ilidiliga ilicidde.					
	11/8/16, identified R2 cognition. The MDS in	mum Data Set (MDS) dated 02 had moderate impaired ndicated R202 required 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.					
	R202 was observed ly	n 11/29/16, at 6:45 p.m. ying in bed after evening pleted. R202 still had long ng nails.				
	R202 was observed in remained very dirty un	n 11/30/16, at 8:16 a.m. n the dining room. Nails nderneath and also had a ed on top of several nails nained.				
	On 11/30/16, at 1:11	o.m. R 202 was observed in				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
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	DOLUBER 65 20050000	00261		TE 710 0005	1 12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA SS LAKE ROAD	TE, ZIP CODE		
ST THERE	ESE HOME		PE, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	Continued From page	24	2 920			
	nails with dark brown underneath. During interview on 1	ve long facial hair and long and black debris 1/30/16, at 1:11 p.m. R202's				
	concern to the facility mother's appearance occasions she had no on her mother's hands also stated that her mand dirty long fingerna with the facility but it of	stated she had expressed previously about her She stated on previous sted bowel movement (BM) and under her nails. She sother having long facial hair ails had been addressed continued to be a common when the state of the stat				
	stated, "My mother washe would be appalled	as a very classy lady and d by this."				
	continued to have lon black/brown substance	n 12/1/16, at 9:26 a.m. R202 g facial hair and se under nails. A sour odor ng from R202's hands.				
	assistant (NA)-B state	2/1/16, at 9:44 a.m. nursing ed residents are shaved with ails are done with bathing.				
	stated residents get s	2/1/16, at 9:50 a.m. NA-C haved with their cares if done with baths and as				
	7					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1127 27.11	or definition	IDENTIFICATION NO.	A. BUILDING: _		00.000	
		00261	B. WING	B. WING		1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		LAKE ROAD			
			E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	O Continued From page 25		2 920			
	R229's admission ME diagnoses of dementi MDS further indicated impairment, and requicomplete personal hy Assessment (CAA) for indicated R229 requiredue to Lewy Body Detremor. R229's care plan, rev R229's abilities with grelated to R229's diagrected: "I may be at Hand me my razor and complete. I need you have my attention while I am unable to complete. I need to be shared to be shared by the first floor. R229 papproximately 1/8 incincluded longer stubben 11/29/16, at 12:04 p. In the dining room for the remained unshaven. Was observed lying as still present and unshappears in his rewith toileting, washing teeth, after which R22 was not shaved, nor was not shaved.	OS dated 8/29/16, included a and anxiety disorder. The displayed R229 had severe cognitive ired extensive assistance to giene. The Care Area or ADLs, dated 8/29/16, red assistance with all ADLs mentia and Parkinsonian dised 11/23/16, identified prooming were variable, gnoses. The care plan able to complete my shaving. In displayed me cues to a to stand on my left side and en you are giving me cues. In plete, I need staff to shave eved every morning." In 11/28/16, at 3:45 p.m. In the dining room area on presented with facial hair, and he growth, which also les under his chin. On m. while seated at a table in the noon meal, R229 Later at 7:22 p.m., R229 sleep in bed, with facial hairs				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00261	B. WING	B. WING		1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST THER	ESE HOME		LAKE ROAD , MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 920	the dining room for brunshaven. During interview on 1 stated R229 was curracknowledged R229 morning during his caforgot it." NA-D state shaved everyday, "but shaved everyday, "but During interview on 1 licensed practical nurwould expect and trustleast offer to shave R that if they were unsut LPN-C said R229 had movements that internand R229 could be restated "we should alwand document refusa. During interview on 1 director of nursing (During observation or was seated in his when the director of nursing observation or	until NA-D assisted R229 to reakfast at 9:12 a.m., still 1/30/16, at 1:46 p.m. NA-D ently unshaven, and was not offered shaving that ares. NA-D stated,"I just d R229 was normally A-D said R229 should be at [R229] just got missed." 1/30/16, at 2:04 p.m. se (LPN)-C stated she st the nursing aides would at 229 every day, and further, ccessful, to "let me know." d behaviors and involuntary fered with completing ADLs, esistive to cares, but then arays, always" keep trying, als of care. 2/1/16, at 1:07 p.m. the ON) stated he would expect sillow their care guide and seded. The DON also said es in charge to monitor staff	2 920			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/01/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
ST THERESE HOME			S LAKE ROAD E, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
2 920	Continued From page	e 27	2 920			
	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."					
	stated she observed l were, "A little bit long,	1/30/16, at 2:00 p.m. LPN-A R44's fingernails and they " and the nurse assigned to ay should have clipped				
	11/2016, identified an finger/toe nails weekly needed]." The record had been completed observed with long fir 11/26/16.	y with bath and PRN [as I identified trimming of nails two days prior to being ngernails by the surveyor on				
	A facility Resident Ca	re: Grooming policy dated				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
		00261	B. WING		12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	•	
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ST THERESE HOME 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 920	Continued From page 28		2 920			
	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					
21385	Staff assistance Subp. 3. Staff assist Personnel must be as infection control programmer.	Subp. 3 Infection Control; ance with infection control. assigned to assist with the ram, based on the needs of sing home, to implement edures of the infection	21385			
	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:					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		00261	B. WING		12/0	1/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		S LAKE ROAD			
		NEW HOP	E, MN 55428			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21385	Continued From page 29		21385			
	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 nur	se (LPN)-placed a pair of 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 seron drainage from R68's	us (pale yellow color) wound. LPN-B discarded the				
	•	ned, dried, and measured moved one of the two pairs				
	of gloves. LPN-B produces of gloves. LPN-B produced dressing while wearing	ceeded to open the new ng the second pair of				
	new dressing over R6	ted gloves and placed the 68's wound. LPN-B stated				
	before donning gloves	ve been washed immediately s and would usually wash in				
		e dirty and clean dressings. it was her routine to double				
	glove and not the faci	ility's policy.				
	•)-D stated gloves should be				
	dressings. RN-D furth	d in between dirty and clean ner stated it was not the ble glove and staff received				
		nand hygiene during wound				
	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 "Opportunity for re-ed	ne observation provided an ducation."				
	The facility policy Infe	ection Control: Use of Gloves				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/01/2016	
	ROVIDER OR SUPPLIER	8000 BASS	RESS, CITY, STA	TE, ZIP CODE		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21385	between tasks on the with material that may concentration of micro directed staff to remorn non-contaminated iter. The facility policy Infedated 2/10, directed shygiene prior to applie gloves. Suggested Method of her designee could reregarding infection coher designee could exprocedures and develensure compliance with Time Period for Correct MN Rule 4658.1400 For A nursing home must functional, comfortable environment, allowing	taff to change gloves in same resident after Contact of contain a high porganisms. It further over gloves before touching ms. ction Control: Hand Hygiene taff to perform hand cation and upon removal of Correction: The DON or view policy and procedures introl program. The DON or ducate staff on policy and op a monitoring system, to the proper hand hygiene. ction: Twenty-one (21) Days Physical Environment It provide a safe, clean, e, and homelike physical If the resident to use	21385 21665			
	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.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00261	B. WING		12/01/2016	\dashv
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME	8000 BAS	S LAKE ROAD			
NEW HOP		E, MN 55428			_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
21665	Continued From page	31	21665			
	finding include:					
	midnig molado.					
	•	the residence kitchen on two wall mounted fans				
		d blowing in the dishwashing				
		an was observed blowing				
		of the dish area where a				
	three tier metal rolling	•				
	observation, two racks of clean dishes, containing					
	serving utensils and clear plastic jugs, came out of the dishwasher on a conveyor belt toward the					
		the wire rings of the fan				
	were covered with ha	_				
	extending from the mi	iddle to the back of the fan.				
		1/28/16, at 10:32 a.m. DM-A				
	• .	substance "Looks like fuzz" be cleaned." DM-A stated				
		art the fans and cleaned				
		ut that one "Must've been				
	missed." DM-A furthe	r stated the cleaned wet				
		the the metal cart in the				
	afternoon to dry then	put away at night.				
	During observation or	n 12/1/16, at 10:14 a.m. the				
	fan was observed cle	aned without any gray fuzz.				
	During interview on 1	2/1/16, at 10:19 a.m. DM-A				
	•	fan was different than the				
		e taken apart to be cleaned.				
		n't say it got missed, I'd say				
		as staff had to climb up to				
		urther stated she would				
		iber that fan needs to be nen completing the task.				
	oleaned dillerently Wi	ion completing the task.				
	A facility policy entitle	d Cleaning of Wall Fans,				
	undated, directed ma	intenance to remove the fan				
		ever, the policy directed the				
	dietary staff to wipe of	ff dust and dirt build up and				- 1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		00261	B. WING		12/0	1/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST THERE	SE HOME		E, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO		BE	(X5) COMPLETE DATE
21665	Continued From page 32		21665			
	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 (21) days.	CORRECTION: Twenty-one				
21805	MN St. Statute 144.69 Residents of HC Fac.		21805			
	residents have the rig courtesy and respect	treatment. Patients and what to be treated with for their individuality by ons providing service in a				
	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:					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12	/01/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE			
ST THER	ESE HOME		S LAKE ROAD PE, MN 55428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21805	R202's quarterly Mining 11/8/16, identified R20 cognition. The MDS in extensive assistance R202's care plan, last grooming/hygiene on needed assist with groonditions including in decreased mobility. To identified R202 had do do not be a conversation of the facial hair was east conversation. R202 words long, jagged fingernal debris under the nails debris under the nails debris under the nails debris and dirty loop do not be a competition of R202 was observed by cares had been competition of R202 was observed in remained very dirty under the facial hair and dirty loop do not not substance note and the facial hair removed in the facial	mum Data Set (MDS) dated 02 had moderate impaired ndicated R202 required of staff with grooming. Trevised for 6/21/16, identified that R202 coming/hygiene related to mpaired cognition and The care plan further ementia/memory loss. Ition in the lounge area on R202 was observed to on her chin and upper lip. asy to visualize during ras also observed to have als that had black and brown of the R202 still had long in grails. In 11/29/16, at 6:45 p.m. wing in bed after evening objected. R202 still had long ing nails. In 11/30/16, at 8:16 a.m. In the dining room. Nails inderneath and also had a red on top of several nails mained. In R 202 was observed in griff with her daughter.	21805				
	nails with dark brown underneath. During interview on11	/30/16, at 1:11 p.m. R202's stated she had expressed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. BUILDING: _						
		00261	B. WING		12/0	1/2016			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE					
ST THERESE HOME 8000 BASS LAKE ROAD NEW HOPE, MN 55428									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE			
21805	mother's appearance occasions she had no on her mother's hand also stated that her mand dirty long fingerna with the facility but it to occurrence. The daug stated, "My mother wishe would be appalled buring observation or continued to have lon black/brown substance was noted to be comically buring interview on 12 assistant (NA)-B stated cares if needed and moderate if needed and get nails needed. During interview on 12 stated residents get is needed and get nails needed. During interview on 13 registered nurse (RN) presence of long facial R202 should have be also stated that nails a baths but should also verified R202's nails with should have been cle cares. SUGGESTED METHOTHER The director of nursin train all staff on reside ensure all residents a respect. The DON or	She stated on previous of the bowel movement (BM) is and under her nails. She nother having long facial hair fails had been addressed continued to be a common of the became weepy and as a very classy lady and do by this." In 12/1/16, at 9:26 a.m. R202 of facial hair and the under nails. A sour odoring from R202's hands. In 12/1/16, at 9:44 a.m. nursing of residents are shaved with the the lails are done with bathing. In 12/1/16, at 9:50 a.m. NA-C thaved with their cares if done with baths and as	21805						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		00261	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE					
21805	Continued From page 35		21805							
	complete audits to ensure compliance.									
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.									

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