DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
April 1, 2024

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN  55428-3118

RE: CCN: 245518
Cycle Start Date: December 28, 2023

Dear Administrator:

On January 25, 2024, we notified you a remedy was imposed. On March 19, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 15, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 28, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of , in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 28, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 15, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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April 1, 2024

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN  55428-3118

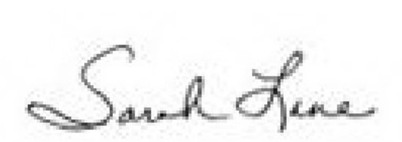
Re: Reinspection Results
Event ID:  ZWY412

Dear Administrator:

On February 28, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 26, 2024.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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February 7, 2024

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN  55428-3118

RE: CCN: 245518
Cycle Start Date: December 28, 2023

Dear Administrator:

On January 25, 2024, we informed you that we may impose enforcement remedies.

On January 26, 2024, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition.  The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 28, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 28, 2024.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 28, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Therese Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 28, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

**determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

## APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245518 | A. BUILDING _____ B. WING _____ | C 01/26/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>On 1/22/24 through 1/26/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 1/22/24 through 1/26/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO deficiencies cited:<br>H55188950C (MN 00092982)<br>H55188949C (MN00093462)<br>H55188942C (MN00090491)<br>H55188880C (MN00093967)<br>H55188879C (MN00094617)<br>H55188948C (MN00098458)<br>H55188944C (MN00095405)<br>H55188933C (MN00092032)<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will | F 000 | | |

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

Electronically Signed | 02/17/2024

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

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| F 000 | Continued From page 1<br>be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for 1 of 1 resident (R103) reviewed for self-administration of medications (SAM) .<br><br>Findings include:<br><br>R103's quarterly Minimum Data Set (MDS) dated 9/26/23, indicated R103 had moderate cognitive impairment.<br>R103's Self Administration of Medication Assessment dated 12/25/2023, indicated assessment for the self-administration of "nebulizer treatment", no other medications were included in the assessment.<br><br>R103's order summary report dated 1/4/2024, indicated SAM orders for Ipratropium-Albuterol nebulizer, Ketotifen Fumarate eye drop, Loratadine, Synthroid, and Trolamine cream. However, no SAM orders for Colace, iron, metoprolol, and Prilosec. | F 554 | Resident 103 has had a new self-administration of medication assessment completed. Medications are being administered per the self-administer of medication assessment, order summary, and plan of care.<br><br>All residents residing at Saint Therese of New Hope have the potential for this deficient practice. All residents residing at Saint Therese of New Hope have been reviewed and self-administration of medications is only occurring for residents if a self- administration assessment has been completed that identifies them as being able to safely self-administer, there is an order to self-administer on the order summary, and it is indicated as being able to self-administer on the plan of care.<br><br>All Nurses and TMA staff have been re-educated on self-administration of medication policy and that medication | 2/23/24 |

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| F 554 | Continued From page 2<br><br>R103's care plan dated 1/25/24, identified SAM orders for some medications. However, Colace, iron, metoprolol, and Prilosec were not included.<br><br>During observation on 1/24/24 at 4:00 p.m., the licensed practical nurse (LPN)-B prepared medications for R103 including; Colace 100 mg (2 capsules), iron 325mg, metoprolol 325mg and Prilosec 20 mg. LPN-B stated all R103's medications were self-administered with nurse set-up. LPN-B brought the medications to R103's room, set them on the table and left the room.<br><br>On 1/25/2024 at 2:40 p.m., registered nurse manager (RN)-B stated residents could be assessed for SAM, if appropriate, on admission. If assessment indicated SAM was appropriate, an order from the physician would be requested. RN-B confirmed R103's orders and assessment did not include Colace, iron, metoprolol, and Prilosec.<br><br>On 1/26/24 at 10:30 a.m., director of nursing (DON) confirmed R103's SAM assessment only listed "nebulizer treatment". DON stated she expected SAM assessments and provider orders for all self-administered medications to ensure resident safety.<br><br>The facility's Resident Self- Administration of Medications policy dated 4/1/2022, indicated each resident has the right to self-administer medication after being assessed and deemed appropriate. The assessment will be recorded in the medical record. | F 554 | must be supervised when administrated unless a self-administration of medication assessment has been completed, there are current orders for the specific mediations to be self-administrated in place and that this information is reflected on the plan of care.<br><br>DON/Designee will complete observation audits for medication pass for self-administration of meds, Audit for completion of self-administration of medication assessments, orders, and updated plans of care for ten (10) residents weekly x 4 weeks, then five (5) residents weekly x 3 weeks, then three (3) residents weekly x two (2) weeks then two (2) residents weekly x 1 month; Audits results and continued need will reviewed at QAPI to determine necessity for further audits once audit schedule is completed. | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) | F 623 | | 2/23/24 |

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| F 623 | Continued From page 3<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or | F 623 | | |

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| F 623 | Continued From page 4<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice. | F 623 | | |

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| F 623 | Continued From page 5<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 3 of 6 residents (R119, R126, R128) upon transfer to the hospital. In addition, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 5 of 6 residents (R119, R128, R45, R50, R59), reviewed for hospitalization. This had the potential to affect all residents transferred to hospital.<br><br>Findings include:<br><br>R119's quarterly MDS dated 1/22/24, indicated R119's diagnoses included dementia with severe cognitive impairment.<br><br>Progress notes indicated R119 was hospitalized from 10/20/23 through 10/24/23.<br><br>R119's record lacked evidence a written | F 623 | R119 has not had any further hospitalizations, R126 and R128 returned from the hospital on 1/25/24 and then went back out on 1/28/24. A bed hold/transfer notice was filled out; R128 has not had any further hospitalizations. Ombudsman has been provided with an updated list of hospital transfers for the past 3 months and R119, R128, R45, R50, and R59 were included on this list.<br><br>All Residents transferred to the hospital residing at Saint Therese of New Hope have the potential for being affected by this deficient practice.<br><br>Social Services staff have been educated on the requirements for written notification of transfer to the resident when transferred to the hospital. Additionally, Social Service staff has been educated on | |

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| F 623 | Continued From page 6<br>notification of transfer was provided to the resident and/or resident representative. Additionally, R119's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R126's admission MDS dated 12/7/23, indicated R126's diagnoses included acute respiratory failure, and R126 was cognitively intact.<br><br>Progress notes indicated R126 was hospitalized from 1/15/24 through 1/25/24.<br><br>R126's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative.<br><br>R128's quarterly MDS dated 1/13/24, indicated R128 was cognitively intact and diagnoses included adult failure to thrive and neuropathy.<br><br>Progress notes indicated R128 was hospitalized from 6/6/23 through 6/20/23.<br><br>R128's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R128's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R45's admission record printed 1/26/2024, indicated R45's diagnoses included pneumonitis due to inhalation of food and vomit, vascular dementia, dysphagia (unable to speak or get words out), and wheezing.<br><br>Progress notes dated 12/1/23, indicated on-call provider was updated after R45 reported labored | F 623 | the requirement to notify the Ombudsman for Long Term Care of resident transfers to the hospital.<br><br>Administrator/Designee will audit all hospital transfers for the next three (3) months for proper documentation for written notification of transfer. Administrator/Designee will audit the monthly list that is provided to the Ombudsman for Long Term Care for discharges to include any transfers to the hospital. Audits results and continued need will review at QAPI to determine necessity for further audits once audit schedule is completed. | |

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| F 623 | Continued From page 7<br>breathing, cough, temperature of 99.6 degrees, respiratory rate of 32 and short shallow breaths. Progress notes further indicated the on-call physician wanted the resident sent into the hospital to be evaluated and was sent to North Memorial via ambulance, and that the facility had updated R45's family of his condition.<br><br>R45's medical record lacked evidence of notification of the Ombudsman of R45's transfer to the hospital.<br><br>R50's quarterly Minimum Data Set (MDS) dated 1/1/24, indicated R50's diagnoses included cerebral palsy, and R50 was cognitively intact.<br><br>Progress notes indicated R50 was hospitalized from 11/28/23 through 11/30/23.<br><br>R50's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R59's admission record printed 1/26/24, indicated R59 diagnoses included diarrhea, cholelithiasis without obstruction (gallstones), and postsurgical malabsorption.<br><br>Progress notes dated 12/11/23, indicated on call provider was updated by facility when R59 reported right side abdominal pain which was not relieved with interventions. Progress notes indicated resident was transferred to emergency department via ambulance. Facility was updated that resident would be admitted for further evaluation.<br><br>R59's medical record lacked evidence of notification of the Ombudsman of R59's transfer to the hospital. | F 623 | | |

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| F 623 | Continued From page 8<br><br>Voluntary discharge notice faxes sent to the Office of the Ombudsman for LTC, undated, included spreadsheets for 1/3/23 through 12/30/23. The spreadsheets included the names, dates, and location for all residents discharged to home or other LTC facilities. However, the spreadsheets did not include the names and dates of residents transferred to the hospital from 1/3/23 through 12/30/23.<br><br>On 1/26/24 at 9:00 a.m. social services director (SSD) stated a Notice of Voluntary Transfer form was provided in the facility's hospital discharge packet, the notice should be filled out with the resident at the time of transfer, and a notice faxed to the ombudsman. SSD acknowledged the process needed improvement and was a "work in progress". SSD stated the Ombudsman for LTC was notified of discharges to home or other facilities, but was not notified of transfers to hospital. SSD acknowledged the ombudsman should have been notified of all discharges, including residents transferred to the hospital.<br><br>A facility policy regarding required notification for transfers/discharges was requested but not provided. | F 623 | | |
| F 625 SS=D | Resident #45<br>Huls, Alex D. (46941)<br>Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2) | F 625 | | 2/23/24 |

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| F 625 | Continued From page 9<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide a written notice of a bed hold upon transfer for hospitalization for 1 of 5 residents (R119) reviewed for hospitalization.<br><br>Findings include:<br><br>R119's quarterly Minimum Data Set (MDS) dated | F 625 | R119 has not had any further hospitalizations.<br><br>All Residents transferred to the hospital residing at Saint Therese of New Hope have the potential for being affected by this deficient practice. | |

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| F 625 | Continued From page 10<br>1/22/24, indicated R119's diagnoses included dementia and severe cognitive impairment.<br><br>A progress note dated 10/20/23 at 10:23 p.m., indicated R119 was sent to the hospital at 6:00 p.m., and was admitted to the Veteran's Administration (VA) hospital for sepsis via urinary source. R119's progress notes had no evidence a bed hold notice was provided to the resident and/or responsible party. A subsequent progress note dated 10/24/23 at 11:14 a.m., indicated R119 returned from the VA hospital on 10/24/23 at 10:57 a.m.<br><br>On 1/25/24 at 9:00 a.m., director of social services (DSS) stated a notice of voluntary transfer form and written notice of bed hold should have been filled out with the resident, and the social worker should have acted as a backup to follow up on a bed hold.<br><br>On 1/26/24 at 12:43 p.m., director of nursing (DON) stated a written notice of bed hold was not provided to R119 for the 10/20/23 to 10/24/23 hospitalization.<br><br>The facility's Bed Hold Notice Upon Transfer dated August 2022, indicated at the time of transfer for hospitalization, the facility would provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. | F 625 | Social Services staff have been educated on the requirements for providing a written notice of bed hold upon transfer for hospitalization.<br><br>Administrator/Designee will audit all hospital transfers for the next three (3) months for proper documentation for written notification of transfer. Administrator/Designee will audit the monthly list that is provided to the Ombudsman for Long Term Care for discharges to include any transfers to the hospital. Audits results and continued need will review at QAPI to determine necessity for further audits once audit schedule is completed. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence. | F 690 | | 2/23/24 |

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| F 690 | Continued From page 11<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure a urinary catheter drainage bag was kept below the level of the bladder to prevent infection for 1 of 1 | F 690 | R121 was on hospice and has expired.<br><br>All residents with catheters residing at Saint Therese of New Hope have the | |

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| F 690 | Continued From page 12<br>residents (R121) reviewed for catheter care.<br><br>Findings include:<br><br>R121's face sheet indicated diagnoses included malignant neoplasm (cancer) of prostate, secondary malignant neoplasm of bone, and metabolic encephalopathy (brain dysfunction due to chemical imbalance).<br><br>R121's quarterly Minimum Data Set (MDS) dated 11/2/23, indicated was severely impaired cognition.<br><br>R121's care plan initiated 7/12/23, indicated at risk for developing a urinary tract infection (UTI) due to catheter use, and staff would provide catheter cares to keep free from catheter related complications.<br><br>On 1/22/24 at 1:40 p.m., R121 was observed seated in his wheelchair in his room, facing the hallway, approximately three feet from the entryway. R121's catheter tubing extended upwards from the bottom of R121's right pant leg, arched approximately three inches above the drainage area at the top of the drainage bag, and the uncovered catheter drainage bag was secured to R121's right armrest. The position of the drainage opening of the drainage bag was approximately six inches above the level of R121's bladder.<br><br>On 1/26/24 at 11:01 a.m., infection preventionist (IP) stated a catheter drainage bag should have been positioned below the level of the bladder and when a resident was seated in a wheelchair, the drainage bag was expected to be secured below the wheelchair seat so urine would drain | F 690 | potential to experience this deficient practice. The catheter bags on all residents with indwelling catheters have been observed to be placed below the level of the bladder to reduce increased risk of infection of UTI.<br>Nursing staff and therapy staff have been educated on proper placement of catheter bags to reduce the risk of urinary tract infections.<br><br>DON/Designee will complete observation audits for proper placement of catheter bags. Fourteen (14) audits will be completed weekly x 4 weeks, then nine (9) audits weekly x 3 weeks, then six (6) audits weekly x two (2) weeks, then two (2) audits weekly x 1 month; Audits results and continued need will reviewed at QAPI to determine necessity for further audits once audit schedule is completed | |

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| F 690 | Continued From page 13<br>properly. Proper placement of a drainage bag was important because if a catheter drainage bag was not positioned below the level of the bladder, the urine could reflux back into the resident's bladder increasing the risk of infection.<br><br>The facility's Indwelling Catheter Use and Removal Policy dated January 2023, indicated indwelling catheter care practices included securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing, and position below the level of the bladder in accordance with current professional standards of practice and infection prevention and control procedures. | F 690 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and | F 761 | | 2/23/24 |

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| F 761 | Continued From page 14<br>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure 3 of 6 medication carts were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications. The deficient practice had the potential to affect all residents that resided on the first and second floors in the facility.<br><br>Findings include:<br><br>On 1/24/24 from 11:02 a.m. to 11:31 a.m., 1st floor medication cart (A) was unlocked and unattended. There were also approximately five to six residents within 10 feet of the open medication cart.<br><br>On 1/24/24 from 11:42 a.m. to 11:51 a.m., 2nd floor medication cart (B) was observed unlocked and unattended. No residents were in the vicinity of the open medication cart.<br><br>On 1/25/24 from 2:14 p.m. to 2:16 p.m., 2nd floor medication cart (C) was observed unlocked and unattended. No residents were in the vicinity of the open medication cart.<br><br>On 1/24/24 at 9:31 a.m., registered nurse manager (RN)-B stated she expected all medication and treatment carts to be locked when unattended. | F 761 | The 3 medication carts identified have all been observed as locked when not in use and/or in direct reach/supervision of a nurse and/or TMA.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>All Nurses and TMAs have been educated on the medication storage policy and expectations of ensuring medications are secured unless in direct reach/supervision of the staff member this includes but is not limited to locking of medication and treatment carts.<br><br>DON/Designee will complete observation audits for locking and secure storage of medications. Audits will be completed as follows: Fourteen (14) audits will be completed weekly x 4 weeks, then nine (9) audits weekly x 3 weeks, then six (6) audits weekly x two (2) weeks, then two (2) audits weekly x 1 month; Audits results and continued need will reviewed at QAPI to determine necessity for further audits once audit schedule is completed. | |

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| F 761 | Continued From page 15<br>On 1/24/24 at 4:00 p.m., licensed practical nurse (LPN)-B stated staff were trained to ensure medication carts were locked when not in use or out of eyesight.<br><br>On 1/25/24 at 9:37 a.m., LPN-A confirmed that medication cart A had been left unlocked and unattended on 1/24/24 from 11:02 a.m. to 11:31 a.m., and should have been locked when unattended.<br><br>On 1/25/24/ at 2:56p.m., director of nursing (DON) stated staff were expected to ensure all medication and treatment carts were locked when unattended for resident safety and security.<br><br>Facility policy Medication Storage dated 4/1/2022, indicated all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) and only authorized staff will have access to the keys to the locked compartments. | F 761 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. | F 812 | | 2/23/24 |

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| F 812 | Continued From page 16<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure food temperatures were taken in the kitchenettes to prevent foodborne illness. This had the potential to affect all 161 residents currently residing in the facility.<br><br>Finding include:<br><br>During an observation of temperature taking of the lunch meal on 1/26/24 at 10:30 a.m., with dining manager (DM) and the campus dining service and purchasing director (CDSPD) the cook documented the temperature of the meat on a Quality Checklist Sheet (QCS) dated 1/26/24. When asked to see the last month of temperature logs the DM produced completed lunch and dinner temperature logs. At 10:50 a.m. the DM stated she did not have any breakfast QCS logs.<br><br>On 1/26/24 at 11:05 a.m. CDSPD produced three QCS logs dated 1/19/24, 1/23/24, and 1/25/24 that had temperatures for the breakfast meal.<br><br>During an interview on 1/26/24 at 11:35 a.m., dining service aid (DSA)-A stated she had served the breakfast that morning and did not have time to take the temperatures. DSA-A stated the temperatures of all food should be taken before serving to the residents on the unit. | F 812 | Food temps are being taken on all 3 floors dining kitchenettes prior to serving food to the residents on all three shifts consistently 7 days per week. No residents were adversely affected by this omitted practice.<br><br>All residents residing at Saint Therese of New Hope have the potential to experience this deficient practice.<br><br>Dietary staff that serves/prepares food for the Kitchen / kitchenettes have been educated on the policy and procedure for checking of food temps, including but not limited to temping food for all meals every day prior to being served to residents from the kitchenette. They have been educated on the appropriate ranges of temperatures of food for safe food consumption for residents and been educated on the risk and benefits.<br><br>Administrator/Designee will complete audits on temperature logs on all three shifts. Fourteen (14) audits will be completed weekly x 4 weeks, then nine (9) audits weekly x 3 weeks, then six (6) audits weekly x two (2) weeks, then two (2) audits weekly x 1 month; Audits results and continued need will review at QAPI to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245518 | A. BUILDING _____ B. WING _____ | C 01/26/2024 |

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

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| F 812 | Continued From page 17<br>During an interview on 1/26/24 at 11:05 a.m. CDSPD stated every meal needed to have the temperature taken prior to serving the food to the residents every day. CDSPD stated that temperature taking was discussed at the last staff meeting.<br><br>The facility policy Food Safety Requirements dated 10/22, indicated when preparing food, staff shall take precautions in critical control point in the food preparation process to prevent, reduce, or eliminate potential hazards. d. Holding-staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. | F 812 | determine necessity for further audits once audit schedule is completed. | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | | 2/23/24 |

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| F 880 | Continued From page 18<br>conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of | F 880 | | |

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| F 880 | Continued From page 19<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement ongoing infection prevention and control program to prevent the spread of infection due to lack of appropriate use of personal protective equipment (PPE) for 1 of 1 resident (R6) on transmission-based precautions (TBP) for COVID-19. In addition, the facility failed to disinfect a multi-use mechanical lift used by COVID positive resident. This affected 2 of 2 residents (R2, R95), and had the potential to affect all 166 residents in the facility.<br><br>Findings include:<br><br>R6's quarterly MDS dated 12/7/23, indicated R6 had moderate cognitive impairment, traumatic brain injury, and bipolar disorder.<br><br>R6's progress noted dated 1/22/24 at 1:57 p.m., indicated positive for COVID-19. R6 was placed on transmission-based droplet precautions, and would remain on isolation precautions until 1/27/24.<br><br>R95's annual Minimum Data Set (MDS) dated 11/21/23, indicated short-term and long-term memory problems, and diagnoses included dementia, adult failure to thrive, and chronic congestive heart failure.<br><br>R2's quarterly MDS dated 1/17/24, indicated | F 880 | R6 is no longer requires PPE r/t Transmission-based precautions. COVID infection has resolved. Equipment utilized with R2 & R95 has been wiped down and disinfected.<br><br>All residents residing at Saint Therese of New Hope have the potential to experience this deficient practice.<br><br>All staff that have direct resident contact have been educated on use of personal protective equipment (PPE).<br><br>All staff utilizing multi-use resident equipment have been educated on requirements of disinfecting to reduce the spread of infections.<br><br>DON/Designee will complete observation audits for application of PPE when providing cares for residents with transmission-based precautions and will complete audits on disinfecting of multi-resident use equipment.<br>Fourteen (14) audits will be completed weekly x 4 weeks, then nine (9) audits weekly x 3 weeks, then six (6) audits weekly x two (2) weeks, then two (2) audits weekly x 1 month; Audits results and continued need will review at QAPI to determine necessity for further audits | |

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| F 880 | Continued From page 20<br>cognitively intact, and diagnoses included paranoid schizophrenia, abnormal weight loss, breast cancer, and bone cancer.<br><br>During observation on 1/25/24 at 9:44 a.m., nursing assistant (NA)-A and NA-B donned personal protective equipment (PPE) prior to entering R6's room. NA-A donned a surgical mask, gown, and gloves; however, NA-A failed to apply a N95 mask and failed to apply eye protection prior to entering R6's room. NA-B applied a N95 mask, gown, and gloves; however, NA-B failed to apply eye protection prior to entering R6's room.<br><br>During observation on 1/25/24 at 9:57 a.m., NA-A exited R6's room still wearing a surgical mask. NA-A then walked from R6's room directly into R95's room.<br><br>On 1/25/24 at 10:01 a.m. NA-A stated R6 was on precautions for COVID-19, a N95 mask should have been worn into R6's room and removed prior to exiting R6's room to prevent the spread of infection.<br><br>On 1/25/24 at 10:07 a.m. NA-B exited R6's room, placed two bags of linens on the hallway floor directly outside of R6's room, rolled a hoyer lift out of R6's room in into the hallway, donned gloves, and entered a soiled utility room with the two bags of linens. However, NA-B failed to disinfect the hoyer lift after it was removed from R6's room.<br><br>On 1/25/24 at 10:12 a.m., following continuous observation of the hoyer lift, NA-B took the unsanitized hoyer lift, with ungloved hands, from the hallway outside of R6's room, removed the | F 880 | once audit schedule is completed. | |

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| F 880 | Continued From page 21<br>battery and placed it into a standing lift, pushed the unsanitized hoyer lift to the end of the hallway, and took the standing lift, with the battery from the unsanitized lift, into R2's room and closed the door.<br><br>On 1/25/24 at 10:23 a.m., infection preventionist (IP) stated measures were in place to prevent the further spread of infection, and staff were expected to look at the precautions signs posted on resident doors and don the required PPE indicated on the sign. For residents with COVID-19, IP expected staff to don a gown, gloves, N95 mask, and eye protection prior to entering the room. Staff were expected to remove their PPE and complete hand hygiene prior to exiting the room and after exiting the room, and staff were expected to keep bags with trash or soiled linens off the floor. Additionally, staff were expected to disinfect lifts used for a resident with COVID-19 with the "purple top" wipes right away and outside of the room.<br><br>COVID(+) Residents in Last 4 Weeks document, undated, indicated 6 residents that resided on the 1st floor of the facility tested positive for COVID-19 from 1/17/24 to 1/24/24.<br><br>COVID(+) Staff in Last 4 Weeks document, undated, indicated 5 staff tested positive for COVID-19 from 1/14/24 to 1/24/24.<br><br>The facility's Coronavirus Prevention and Response policy dated October 2022, indicated the facility will respond promptly to identify, treat, and prevent the spread of the COVID-19 virus. Facility staff who enter the room of a resident with COVID-19 infection should adhere to standard precautions and use a N95, gown, gloves and | F 880 | | |

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| F 880 | Continued From page 22<br>eye protection.<br><br>The facility's Cleaning and Disinfection of Resident-Care Equipment policy dated September 2023, indicated resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendation in order to break the chain of infection, and multiple-resident use equipment shall be cleaned and disinfected after each use. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza | F 883 | | 2/23/24 |

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| F 883 | Continued From page 23<br>immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 5 residents (R121, R147) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). | F 883 | R121 has expired; Resident R147 has been offered the PVC20 and has declined. Risk/benefits have been explained and he verbalized an understanding.<br><br>All residents at Saint Therese of New Hope have the potential to experience this | |

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| F 883 | Continued From page 24<br>Findings include:<br><br>A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old.<br><br>R121's immunization report, dated 1/26/2024, indicated R121 was 93 years old, received PPSV23 on 5/24/2004 and PCV13 on 9/24/2014. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R121 was offered or received PCV20.<br><br>R147's immunization report, dated 1/26/24, indicated R147 was 84 years old, received PPSV23 on 1/30/2018 and PCV13 on 9/14/2015. The record lacked evidence of shared clinical decision-making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R147 was offered or received PCV20.<br><br>On 1/26/24 at 11:01 a.m. infection preventionist (IP) stated R121 and R147 pneumococcal vaccination status was considered "up-to-date" because both residents had already received PPSV23 and PCV13, and was not aware shared | F 883 | deficient practice. All resident□s immunization records have been reviewed. All residents residing at the facility are either current with the pneumococcal immunization or the chart contains documentation of being the vaccination being offered and declined by the resident.<br><br>Infection preventionist has been educated on the immunization policy and requirements of offering, administering, and documenting historical immunizations, any vaccinations administrations and/or any declinations by the resident.<br><br>DON/Designee will complete audits vaccination records of fourteen (14) residents charts weekly x 4 weeks, to ensure pneumococcal vaccinations are current and up-to-date and/or if they were offered and/or declined if review indicates they are needed; then nine (9) audits weekly x 3 weeks, then six (6) audits weekly x two (2) weeks, then two (2) audits weekly x 1 month; Audits results and continued need will reviewed at QAPI to determine necessity for further audits once audit schedule is completed. | |

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| F 883 | Continued From page 25<br>clinical decision-making with the physician for PCV20 was required. IP verified R121 and R147 had not been offered or provided education on PCV20, and there had been no shared clinical decision-making with the resident providers regarding pneumococcal immunizations for R121 and R147.<br><br>The facility's Pneumococcal Vaccine Policy dated 4/1/22, indicated the type of pneumococcal vaccine offered would depend upon the resident's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. | F 883 | | |

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| | 245518 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/24/2024** |

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| **ST THERESE HOME** | **8000 BASS LAKE ROAD**<br>**NEW HOPE, MN 55428** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/24/2024. At the time of this survey, St. Therese Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 02/17/2024 |

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

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>St Therese Home is a 3-story building with no basement. The building was constructed at four different times. The original building was constructed in 1968 and was determined to be of Type I (332) construction. In 1973, an addition was constructed to the 3rd floor that was determined to be of Type II (111) construction. In 1999, an addition was constructed to the west side of the 1st floor that was determined to be of Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245518 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/24/2024** |

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

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| K 000 | Continued From page 2<br>determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an existing building of this height, the building is surveyed as one building. The building is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification.<br><br>The facility has a capacity of 168 beds and had a census of 164 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 225<br>SS=F | Stairways and Smokeproof Enclosures<br>CFR(s): NFPA 101<br><br>Stairways and Smokeproof Enclosures<br>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.<br>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain stairwell access per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 19.2.2.2.5.2, and 7.2.1.5.10.1. This deficient finding could have a widespread impact on the residents within the facility. | K 225 | Action to correct the deficient practice:<br>The emergency egress doors leading into the stairwells in the facility will have mag locks installed with a 15 second delay. The door handle is lower that the 48 so it would meet the standards. | 2/23/24 |

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| K 225 | Continued From page 3<br><br>Findings include:<br><br>On 01/24/2024 at 10:58 AM, it was revealed by observation that the buttons that unlock the emergency egress doors leading into the stairwells in the facility were mounted higher than the maximum 48".<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient finding at the time of discovery. | K 225 | Measures that will be put in place to ensure that the deficient practice does not occur: All future locks will be egress locks.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is March 31st, 2024. | |
| K 324 SS=D | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the | K 324 | | 2/23/24 |

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| | 245518 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/24/2024** |

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| K 324 | Continued From page 4<br>corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, a review of available documentation, and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/24/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility provided a kitchen hood inspection report that was completed in August of 2023, but they could not provide a report for an inspection being completed six months before the last inspection.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient finding at the time of discovery. | K 324 | Action to correct the deficient practice: The facility has a preventative maintenance plan that has the kitchen hoods professionally inspected every 6 months. The inspection did occur in 2023, but there was no documentation at the time of survey.<br><br>Measures that will be put in place to ensure that the deficient practice does not occur: Facility will ensure that inspection records are obtained and maintained within the facility. Documentation of the inspection that occurred in 2023 has been obtained and filed within facility documentation.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br><br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 23rd, 2024. | |

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| K 346 | Continued From page 5 | K 346 | | |
| K 346 SS=C | Fire Alarm System - Out of Service<br>CFR(s): NFPA 101<br><br>Fire Alarm - Out of Service<br>Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/24/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy that was provided at the time of the survey was last reviewed in 2013 and the contact information for the State Fire Marshal was no longer valid.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient finding at the time of discovery. | K 346 | Action to correct the deficient practice: The facility will implement an out-of-service if the fire alarm is out for more than 4 hours in a 24-hour service period. A fire watch will be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.<br><br>Measures that will be put in place to ensure that the deficient practice does not occur: Facility will ensure that the out of service policy is updated with current State Fire Marshal information.<br><br>Policy will be implemented when necessary.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. | 2/23/24 |

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| K 346 | Continued From page 6 | K 346 | Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 23rd, 2024. | |
| K 353 SS=C | Sprinkler System - Maintenance and Testing CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. | K 353 | Action to correct the deficient practice: The facility will ensure that all electrical conduits attached to the sprinkler pipe to include the 6 identified during inspection are detached to comply with NFPA 101 (2012 Edition), Life Safety Code section 9.7.5, NFPA 25 (2011 Edition), Standards for the Inspection, Testing and Maintenance of water-based fire | 2/23/24 |

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| K 353 | Continued From page 7<br><br>Findings include:<br><br>1. On 01/24/2024 at 10:58 AM, it was revealed by observation that there was a section of electrical conduit attached to the sprinkler pipe above the smoke barrier doors going into 3 west.<br><br>2. On 01/24/2024 at 11:02 AM, it was revealed by observation that there was a section of electrical conduit attached to the sprinkler pipe above the smoke barrier doors going into 3 east.<br><br>3. On 01/24/2024 at 11:26 AM, it was revealed by observation that there were wires attached to the sprinkler pipe in the TR storage room 186.<br><br>4. On 01/24/2024 at 11:29 AM, it was revealed by observation that there were wires attached to the sprinkler pipe in the maintenance shop on the first floor.<br><br>5. On 01/24/2024 at 11:33 AM, it was revealed by observation that there were coax wires attached to the sprinkler pipe in the storage room 191.<br><br>6. On 01/24/2024 at 11:35 AM, it was revealed by observation that there were wires attached to the sprinkler pipe outside of classroom 190 on the first floor.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified these deficient findings at the time of discovery. | K 353 | protection systems, section 5.2.2.2.<br><br>Measures that will be put in place to ensure that the deficient practice does not occur: Any new wiring installation/replacement at the facility will meet the codes above. The existing wiring will be in compliance after the deficiency is remedied.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br><br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 29th, 2024. | |
| K 354<br>SS=C | Sprinkler System - Out of Service<br>CFR(s): NFPA 101<br><br>Sprinkler System - Out of Service | K 354 | | 2/23/24 |

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| K 354 | Continued From page 8<br>Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 01/24/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler out-of-service policy that was provided at the time of the survey was last reviewed in 2013 and the contact information for the State Fire Marshal was no longer valid.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient | K 354 | Action to correct the deficient practice: The facility will ensure that where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or the portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. The policy that guides this practice has been updated to mimic NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.1 and 9.7.5 and NFPA 25 (2011 Edition), standard for the inspection, testing and Maintenance of water-based Fire Protection Systems, section 15.5.2. The policy has also been updated with the correct contact information for the State Fire Marshal.<br><br>Measures that will be put in place to ensure that the deficient practice does not occur: Facility will ensure that the out of service policy is updated with current | |

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| K 354 | Continued From page 9<br>finding at the time of discovery. | K 354 | State Fire Marshal information. Policy will be implemented when necessary.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br><br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 29th, 2024. | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. | K 712 | Action to correct the deficient practice: Facility will continue holding fire drills as scheduled at expected and unexpected times under varying conditions at least quarterly on each shift. | 2/23/24 |

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| K 712 | Continued From page 10<br><br>Findings include:<br><br>On 01/24/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the third shift during the fourth quarter of 2023.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient finding at the time of discovery. | K 712 | Measures that will be put in place to ensure that the deficient practice does not occur: Facility will ensure that the drills held per schedule are documented.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br><br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 29th, 2024. | |
| K 901 SS=F | Fundamentals - Building System Categories CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact | K 901 | Action to correct the deficient practice: Facility will ensure that the systems are designed to meet category 1-4 requirements as detailed in the NFPA 99, in form of a risk assessment. | 2/23/24 |

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| K 901 | Continued From page 11<br>on the residents within the facility.<br><br>Findings include:<br><br>On 01/24/2024 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the NFPA 99 risk assessment that the facility provided at the time of the survey was missing chapters 10 and 11.<br><br>An interview with the Executive Director and Plant Operations Supervisor verified this deficient finding at the time of discovery. | K 901 | Measures that will be put in place to ensure that the deficient practice does not occur: Facility has implemented the risk assessment per NFPA (2012 Edition) that also covers chapters 10 and 11.<br><br>How we will monitor future performance to ensure solutions are sustained: Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance.<br><br>Who is responsible: The Plant Operations Director/Designee is responsible for compliance with this tag. The date for completion with this tag is February 23rd, 2024. | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 7, 2024

Administrator
St Therese Home
8000 Bass Lake Road
New Hope, MN  55428-3118

Re: State Nursing Home Licensing Orders
Event ID: ZWY411

Dear Administrator:

The above facility was surveyed on January 22, 2024 through January 26, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00261 | A. BUILDING: _____ B. WING _____ | C 01/26/2024 |

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

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 1/22/24 through 1/26/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>identify the date when they will be completed.<br><br>The following complaints were reviewed during the survey:<br>H55188950C (MN 00092982)<br>H55188949C (MN00093462)<br>H55188942C (MN00090491)<br>H55188880C (MN00093967)<br>H55188879C (MN00094617)<br>H55188948C (MN00098458)<br>H55188944C (MN00095405)<br>H55188933C (MN00092032)<br>and NO licensing orders were issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 2 000 | | |
| 2 910 | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence<br><br>Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and<br>B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | 2 910 | | 2/23/24 |

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| 2 910 | Continued From page 3<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure a urinary catheter drainage bag was kept below the level of the bladder to prevent infection for 1 of 1 residents (R121) reviewed for catheter care.<br><br>Findings include:<br><br>R121's face sheet indicated diagnoses included malignant neoplasm (cancer) of prostate, secondary malignant neoplasm of bone, and metabolic encephalopathy (brain dysfunction due to chemical imbalance).<br><br>R121's quarterly Minimum Data Set (MDS) dated 11/2/23, indicated was severely impaired cognition.<br><br>R121's care plan initiated 7/12/23, indicated at risk for developing a urinary tract infection (UTI) due to catheter use, and staff would provide catheter cares to keep free from catheter related complications.<br><br>On 1/22/24 at 1:40 p.m., R121 was observed seated in his wheelchair in his room, facing the hallway, approximately three feet from the entryway. R121's catheter tubing extended upwards from the bottom of R121's right pant leg, arched approximately three inches above the drainage area at the top of the drainage bag, and the uncovered catheter drainage bag was secured to R121's right armrest. The position of the drainage opening of the drainage bag was approximately six inches above the level of R121's bladder. | 2 910 | Corrected | |

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| 2 910 | Continued From page 4<br><br>On 1/26/24 at 11:01 a.m., infection preventionist (IP) stated a catheter drainage bag should have been positioned below the level of the bladder and when a resident was seated in a wheelchair, the drainage bag was expected to be secured below the wheelchair seat so urine would drain properly. Proper placement of a drainage bag was important because if a catheter drainage bag was not positioned below the level of the bladder, the urine could reflux back into the resident's bladder increasing the risk of infection.<br><br>The facility's Indwelling Catheter Use and Removal Policy dated January 2023, indicated indwelling catheter care practices included securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing, and position below the level of the bladder in accordance with current professional standards of practice and infection prevention and control procedures.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review and/or develop policies and provide education for staff regarding proper catheter care to prevent infection. In addition the DON/ designee could audit residents for proper catheter care. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.<br><br>Time Period for Correction: Twenty-one (21) days. | 2 910 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing | 21375 | | 2/23/24 |

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| 21375 | Continued From page 5<br>home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement ongoing infection prevention and control program to prevent the spread of infection due to lack of appropriate use of personal protective equipment (PPE) for 1 of 1 resident (R6) on transmission-based precautions (TBP) for COVID-19. In addition, the facility failed to disinfect a multi-use mechanical lift used by COVID positive resident. This affected 2 of 2 residents (R2, R95), and had the potential to affect all 166 residents in the facility.<br><br>Findings include:<br><br>R6's quarterly MDS dated 12/7/23, indicated R6 had moderate cognitive impairment, traumatic brain injury, and bipolar disorder.<br><br>R6's progress noted dated 1/22/24 at 1:57 p.m., indicated positive for COVID-19. R6 was placed on transmission-based droplet precautions, and would remain on isolation precautions until 1/27/24.<br><br>R95's annual Minimum Data Set (MDS) dated 11/21/23, indicated short-term and long-term memory problems, and diagnoses included dementia, adult failure to thrive, and chronic congestive heart failure.<br><br>R2's quarterly MDS dated 1/17/24, indicated cognitively intact, and diagnoses included | 21375 | Corrected | |

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| 21375 | Continued From page 6<br><br>paranoid schizophrenia, abnormal weight loss, breast cancer, and bone cancer.<br><br>During observation on 1/25/24 at 9:44 a.m., nursing assistant (NA)-A and NA-B donned personal protective equipment (PPE) prior to entering R6's room. NA-A donned a surgical mask, gown, and gloves; however, NA-A failed to apply a N95 mask and failed to apply eye protection prior to entering R6's room. NA-B applied a N95 mask, gown, and gloves; however, NA-B failed to apply eye protection prior to entering R6's room.<br><br>During observation on 1/25/24 at 9:57 a.m., NA-A exited R6's room still wearing a surgical mask. NA-A then walked from R6's room directly into R95's room.<br><br>On 1/25/24 at 10:01 a.m. NA-A stated R6 was on precautions for COVID-19, a N95 mask should have been worn into R6's room and removed prior to exiting R6's room to prevent the spread of infection.<br><br>On 1/25/24 at 10:07 a.m. NA-B exited R6's room, placed two bags of linens on the hallway floor directly outside of R6's room, rolled a hoyer lift out of R6's room in into the hallway, donned gloves, and entered a soiled utility room with the two bags of linens. However, NA-B failed to disinfect the hoyer lift after it was removed from R6's room.<br><br>On 1/25/24 at 10:12 a.m., following continuous observation of the hoyer lift, NA-B took the unsanitized hoyer lift, with ungloved hands, from the hallway outside of R6's room, removed the battery and placed it into a standing lift, pushed the unsanitized hoyer lift to the end of the hallway, | 21375 | | |

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| 21375 | Continued From page 7<br><br>and took the standing lift, with the battery from the unsanitized lift, into R2's room and closed the door.<br><br>On 1/25/24 at 10:23 a.m., infection preventionist (IP) stated measures were in place to prevent the further spread of infection, and staff were expected to look at the precautions signs posted on resident doors and don the required PPE indicated on the sign. For residents with COVID-19, IP expected staff to don a gown, gloves, N95 mask, and eye protection prior to entering the room. Staff were expected to remove their PPE and complete hand hygiene prior to exiting the room and after exiting the room, and staff were expected to keep bags with trash or soiled linens off the floor. Additionally, staff were expected to disinfect lifts used for a resident with COVID-19 with the "purple top" wipes right away and outside of the room.<br><br>COVID(+) Residents in Last 4 Weeks document, undated, indicated 6 residents that resided on the 1st floor of the facility tested positive for COVID-19 from 1/17/24 to 1/24/24.<br><br>COVID(+) Staff in Last 4 Weeks document, undated, indicated 5 staff tested positive for COVID-19 from 1/14/24 to 1/24/24.<br><br>The facility's Coronavirus Prevention and Response policy dated October 2022, indicated the facility will respond promptly to identify, treat, and prevent the spread of the COVID-19 virus. Facility staff who enter the room of a resident with COVID-19 infection should adhere to standard precautions and use a N95, gown, gloves and eye protection.<br><br>The facility's Cleaning and Disinfection of | 21375 | | |

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| 21375 | Continued From page 8<br><br>Resident-Care Equipment policy dated September 2023, indicated resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendation in order to break the chain of infection, and multiple-resident use equipment shall be cleaned and disinfected after each use.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee should review/revise facility policies to ensure they contain all components of an infection control program, immediate implementation of droplet precautions to mitigate COVID-19 transmission, and ensure the appropriate use of PPE and disinfection of multi-use equipment are being performed appropriately and timely. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.<br><br>Time Period for Correction: Twenty-one (21) days. | 21375 | | |
| 21925 | MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before | 21925 | | 2/23/24 |

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| 21925 | Continued From page 9<br><br>transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a written notification of transfer was provided for 3 of 6 residents (R119, R126, R128) upon transfer to the hospital. In addition, the facility failed to notify the Ombudsman for Long Term Care (LTC) of resident transfers to the hospital for 5 of 6 residents (R119, R128, R45, R50, R59), reviewed for hospitalization. This had the potential to affect all residents transferred to hospital.<br><br>Findings include:<br><br>R119's quarterly MDS dated 1/22/24, indicated R119's diagnoses included dementia with severe cognitive impairment.<br><br>Progress notes indicated R119 was hospitalized | 21925 | Corrected | |

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| 21925 | Continued From page 10<br>from 10/20/23 through 10/24/23.<br><br>R119's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R119's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R126's admission MDS dated 12/7/23, indicated R126's diagnoses included acute respiratory failure, and R126 was cognitively intact.<br><br>Progress notes indicated R126 was hospitalized from 1/15/24 through 1/25/24.<br><br>R126's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative.<br><br>R128's quarterly MDS dated 1/13/24, indicated R128 was cognitively intact and diagnoses included adult failure to thrive and neuropathy.<br><br>Progress notes indicated R128 was hospitalized from 6/6/23 through 6/20/23.<br><br>R128's record lacked evidence a written notification of transfer was provided to the resident and/or resident representative. Additionally, R128's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R45's admission record printed 1/26/2024, indicated R45's diagnoses included pneumonitis due to inhalation of food and vomit, vascular dementia, dysphagia (unable to speak or get words out), and wheezing. | 21925 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21925 | Continued From page 11<br><br>Progress notes dated 12/1/23, indicated on-call provider was updated after R45 reported labored breathing, cough, temperature of 99.6 degrees, respiratory rate of 32 and short shallow breaths. Progress notes further indicated the on-call physician wanted the resident sent into the hospital to be evaluated and was sent to North Memorial via ambulance, and that the facility had updated R45's family of his condition.<br><br>R45's medical record lacked evidence of notification of the Ombudsman of R45's transfer to the hospital.<br><br>R50's quarterly Minimum Data Set (MDS) dated 1/1/24, indicated R50's diagnoses included cerebral palsy, and R50 was cognitively intact.<br><br>Progress notes indicated R50 was hospitalized from 11/28/23 through 11/30/23.<br><br>R50's record lacked evidence the Ombudsman for LTC was notified of transfer to the hospital.<br><br>R59's admission record printed 1/26/24, indicated R59 diagnoses included diarrhea, cholelithiasis without obstruction (gallstones), and postsurgical malabsorption.<br><br>Progress notes dated 12/11/23, indicated on call provider was updated by facility when R59 reported right side abdominal pain which was not relieved with interventions. Progress notes indicated resident was transferred to emergency department via ambulance. Facility was updated that resident would be admitted for further evaluation.<br><br>R59's medical record lacked evidence of notification of the Ombudsman of R59's transfer | 21925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00261 | A. BUILDING: _____ B. WING _____ | C 01/26/2024 |

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

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| 21925 | Continued From page 12<br>to the hospital.<br><br>Voluntary discharge notice faxes sent to the Office of the Ombudsman for LTC, undated, included spreadsheets for 1/3/23 through 12/30/23. The spreadsheets included the names, dates, and location for all residents discharged to home or other LTC facilities. However, the spreadsheets did not include the names and dates of residents transferred to the hospital from 1/3/23 through 12/30/23.<br><br>On 1/26/24 at 9:00 a.m. social services director (SSD) stated a Notice of Voluntary Transfer form was provided in the facility's hospital discharge packet, the notice should be filled out with the resident at the time of transfer, and a notice faxed to the ombudsman. SSD acknowledged the process needed improvement and was a "work in progress". SSD stated the Ombudsman for LTC was notified of discharges to home or other facilities, but was not notified of transfers to hospital. SSD acknowledged the ombudsman should have been notified of all discharges, including residents transferred to the hospital.<br><br>A facility policy regarding required notification for transfers/discharges was requested but not provided.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure proper discharge notice is given for residents, and to ensure the ombudsman received notification of all hospitalizations. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) proper discharge notice and | 21925 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| 21925 | Continued From page 13<br>ombudsmn notification was provided. The results of these audits could be reviewed by the quality assurance committee to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 21925 | | |