Electronically delivered
March 26, 2021

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

RE: CCN: 245518
Cycle Start Date: March 11, 2021

Dear Administrator:

On March 11, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 11, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 11, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 26, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 75DN11

Dear Administrator:

The above facility was surveyed on March 10, 2021 through March 11, 2021 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	C 03/11/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/10/21-3/11/21, a standard abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be OUT of compliance with the MN State Licensure. The following complaints were found to be UNSUBSTANTIATED: H5518124C (MN67488	2 000	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.	

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2 000	Continued From page 1 and MN67438) H5518125C (MN67392). The following complaints were found to be SUBSTANTIATED: H5518123C (MN70661) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		4/12/21

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2 830	Continued From page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and assess skin integrity for 1 of 3 residents (R1) who were reviewed for incontinence care. Findings include: R1's annual Minimum Data Set (MDS) dated 2/9/21, indicated R1 had diagnoses that included severe cognitive impairment, dementia, and frequent incontinence of bowel and bladder. R1's Care Area Assessment (CAA) dated 2/11/21, indicated R1 was at increased risk for skin breakdown due to bowel and bladder incontinence, need for assistance with hygiene cares, and impaired cognition. R1's Quarterly Review Assessment dated 3/11/21, indicated R1 had candidiasis and a rash. R1's orders dated 8/19/20, indicated Nystatin powder was ordered for candidiasis. R1's care plan dated 11/15/20, indicated R1 was at risk for skin breakdown and bruising related to eczema, impaired mobility, complications of diabetes, impaired cognition, and incontinence. Interventions included staff repositioning every two hours and as needed, trimming nails to minimize risk from scratching, and pressure	2 830	N/A	

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2 830	Continued From page 3	2 830		

relieving devices. R1's care plan lacked any non pharmcalogical interventions to address R1's rash flare up.

R1's treatment administration record (TAR) indicated a weekly skin assessment with progress note documentation was required on R1's bath day. The note was to include a description of the current skin condition, nail care, and if current skin care plan interventions were in place.

R1's progress note dated 2/12/21, indicated nurse practitioner (NP)-A was notified of R1's worsening rash.

R1's progress notes lacked skin assessments on 2/17/21, 2/24/21, and 3/3/21.

During an continuous observation on 3/10/21, from 9:40 a.m. until 11:40 a.m., R1's door was closed and remained closed until 10:31 a.m. when nursing assistant (NA)-A knocked on R1's door. NA-A opened R1's door slightly and looked in; without saying anything, NA-A shut R1's door and continued down the hallway. At 11:02 a.m. licensed practical nurse (LPN)-A and NA-B entered R1's room.

During an observaion of morning cares at 11:05 a.m. on 3/10/21, R1 was awake and talkative with staff. R1's room smelled of urine. NA-B explained to R1 the cares that were going to be done. R1 stated no, but NA-B redirected R1 to allow the cares to occur. R1 did not want to get up to the chair and stated, "I'm tired". R1 also stated a need to use the bathroom. R1 continued to decline help to get up to bathroom but allowed the bed bath. When R1's bath was completed LPN-A placed Nystatin powder on R1's upper body rash. R1 became restless when care started

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2 830	Continued From page 4	2 830		

on her lower body. R1 was rubbing her legs around her incontinent product stating "help me, hurry up ...I don't want to die ...I need my baby". The inconditnent produce was wet when removed. R1's rash covered the entire buttocks area, extending down to mid-thigh and up to hip region. R1's rash had irregular borders and was red and appeared raw. Small scratch marks that were slightly raised and red were on lower buttocks region. R1 was trying to reach her buttocks area and her hand was re-directed by NA-B. LPN-A applied ointment to rash area after cleansing and a clean incontinent product was applied. As cares were completed at 11:25 a.m., R1 was assisted to the bathroom with lift equipment, voided, and was cleaned and assisted back in bed at 11:40 a.m.

When interviewed on 3/10/21, at 11:45 a.m. LPN-A stated R1 has had skin issues off and on for over a year. R1's rash would flare up then go back to normal, but never really went away. LPN-A stated R1's rash was in a flare up at this time. LPN-A stated R1's rash has also been on other areas of the body. LPN-A stated when in a flare up, they try to reduce any sweating or moisture to the bottom area and maybe reposition more frequently. LPN-A stated these are not in the care plan, but are handed off through verbal report from shift to shift. LPN-A stated skin assessments are completed weekly with R1's bath and documented in a progress note. LPN-A stated changes noted would be reported to NP-A. LPN-A stated R1's current skin flare up started before their hospitalization from 3/4/21-3/5/21 and appears the same.

When interviewed on 3/10/21, at 2:55 p.m. regstered nurse (RN) -A stated R1 has had these rashes off and on for years. RN-A was not sure if

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2 830	Continued From page 5 the rash was from incontinence, as it does get better without changes to intervention in the care plan. RN-A stated they expect a skin assessment for R1 be completed on bath days. Documentation of the assessment should be in the TAR as well as a progress note. RN-A verified R1 had missing skin assessments, with no refusals documented, for the dates of 2/17/21, 2/24/21, and 3/3/21. When interviewed on 3/10/21, at 3:50 p.m. RN-B confirmed there were no skin assessment progress notes for R1 on 2/17/21, 2/24/21, and 3/3/21. RN-B verified it was their shift when these misses occurred. RN-B stated they are not aware of what R1's skin looks like currently and cannot speak to how R1's skin looked during those missing dates due to the nature of R1's rash changing "all the time". When interviewed on 3/11/21, at 10:15a.m. assistant director of nursing (ADON) stated it was expected for residents to have skin assessments performed and documented weekly with their baths. Documentation of the assessments should happen during the shift the assessment was completed. The ADON also stated if skin concerns were found, the staff should involve the provider and nurse manager. All skin complications are discussed daily in rounds. When interviewed on 3/11/21, at 12:15 p.m. NP-A stated she had assessed R1's skin on 2/16/21, but did not assess R1's rash since R1's return from the hospital on 3/5/21. NP-A verified at last visit on 3/8/21, R1 was sitting up in the chair and did not want to get back to bed. NP-A stated she relied on nursing staff to communicate changes in R1's skin. NP-A stated most of the communication was in person or through a page.	2 830		

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2 830	Continued From page 6 NP-A's understanding was R1's rash was the same as it was before hospitalization. NP-A stated this was what nursing had indciated earlier in the week. NP-A verified incontinence can aggravate the rash on R1's bottom and thighs. It was the expectation of NP-A stated it was her expectation that with all incontinent care, skin was noted by the nursing assistant and told to the nurse if skin does not look right. On 3/11/21, the facility's skin monitoring policy was requested and was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident's skin audits is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care related to skin audits as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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

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F 000	INITIAL COMMENTS On 3/10/21-3/11/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5518123C (MN70661) at F684. The following complaint was found to be UNSUBSTANTIATED: H5518124C (MN67488 and MN67438) H5518125C (MN67392). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		4/12/21

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

Electronically Signed | 04/06/2021

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 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and assess skin integrity for 1 of 3 residents (R1) who were reviewed for incontinence care. Findings include: R1's annual Minimum Data Set (MDS) dated 2/9/21, indicated R1 had diagnoses that included severe cognitive impairment, dementia, and frequent incontinence of bowel and bladder. R1's Care Area Assessment (CAA) dated 2/11/21, indicated R1 was at increased risk for skin breakdown due to bowel and bladder incontinence, need for assistance with hygiene cares, and impaired cognition. R1's Quarterly Review Assessment dated 3/11/21, indicated R1 had candidiasis and a rash. R1's orders dated 8/19/20, indicated Nystatin powder was ordered for candidiasis. R1's care plan dated 11/15/20, indicated R1 was at risk for skin breakdown and bruising related to eczema, impaired mobility, complications of diabetes, impaired cognition, and incontinence. Interventions included staff repositioning every two hours and as needed, trimming nails to minimize risk from scratching, and pressure relieving devices. R1's care plan lacked any non pharmcalogical interventions to address R1's rash flare up. R1's treatment administration record (TAR)	F 684	Preparation, submission, and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Late entry documentation for the weekly skin assessments for R1 were completed for dates 2/17/21,2/24/21 and 3/3/21 by RN B. 2. All residents have had weekly skin assessments completed within the past 7 days. 3. Licensed Nursing staff have been educated on the policy and expectation of Saint Therese for weekly skin assessments to be completed and documented weekly. 4. The DON or designee will complete 10 audits each week to ensure that the skin integrity is monitored and assessed through the weekly skin assessment documentation.	

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	245518	A. BUILDING _____ B. WING _____	C 03/11/2021

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F 684	Continued From page 2	F 684		

indicated a weekly skin assessment with progress note documentation was required on R1's bath day. The note was to include a description of the current skin condition, nail care, and if current skin care plan interventions were in place.

R1's progress note dated 2/12/21, indicated nurse practitioner (NP)-A was notified of R1's worsening rash.

R1's progress notes lacked skin assessments on 2/17/21, 2/24/21, and 3/3/21.

During an continuous observation on 3/10/21, from 9:40 a.m. until 11:40 a.m., R1's door was closed and remained closed until 10:31 a.m. when nursing assistant (NA)-A knocked on R1's door. NA-A opened R1's door slightly and looked in; without saying anything, NA-A shut R1's door and continued down the hallway. At 11:02 a.m. licensed practical nurse (LPN)-A and NA-B entered R1's room.

During an observaion of morning cares at 11:05 a.m. on 3/10/21, R1 was awake and talkative with staff. R1's room smelled of urine. NA-B explained to R1 the cares that were going to be done. R1 stated no, but NA-B redirected R1 to allow the cares to occur. R1 did not want to get up to the chair and stated, "I'm tired". R1 also stated a need to use the bathroom. R1 continued to decline help to get up to bathroom but allowed the bed bath. When R1's bath was completed LPN-A placed Nystatin powder on R1's upper body rash. R1 became restless when care started on her lower body. R1 was rubbing her legs around her incontinent product stating "help me, hurry up ...I don't want to die ...I need my baby". The inconditnent produce was wet when

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F 684	Continued From page 3	F 684		

removed. R1's rash covered the entire buttocks area, extending down to mid-thigh and up to hip region. R1's rash had irregular borders and was red and appeared raw. Small scratch marks that were slightly raised and red were on lower buttocks region. R1 was trying to reach her buttocks area and her hand was re-directed by NA-B. LPN-A applied ointment to rash area after cleansing and a clean incontinent product was applied. As cares were completed at 11:25 a.m., R1 was assisted to the bathroom with lift equipment, voided, and was cleaned and assisted back in bed at 11:40 a.m.

When interviewed on 3/10/21, at 11:45 a.m. LPN-A stated R1 has had skin issues off and on for over a year. R1's rash would flare up then go back to normal, but never really went away. LPN-A stated R1's rash was in a flare up at this time. LPN-A stated R1's rash has also been on other areas of the body. LPN-A stated when in a flare up, they try to reduce any sweating or moisture to the bottom area and maybe reposition more frequently. LPN-A stated these are not in the care plan, but are handed off through verbal report from shift to shift. LPN-A stated skin assessments are completed weekly with R1's bath and documented in a progress note. LPN-A stated changes noted would be reported to NP-A. LPN-A stated R1's current skin flare up started before their hospitalization from 3/4/21-3/5/21 and appears the same.

When interviewed on 3/10/21, at 2:55 p.m. regstered nurse (RN) -A stated R1 has had these rashes off and on for years. RN-A was not sure if the rash was from incontinence, as it does get better without changes to intervention in the care plan. RN-A stated they expect a skin assessment

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F 684	Continued From page 4	F 684		

for R1 be completed on bath days. Documentation of the assessment should be in the TAR as well as a progress note. RN-A verified R1 had missing skin assessments, with no refusals documented, for the dates of 2/17/21, 2/24/21, and 3/3/21.

When interviewed on 3/10/21, at 3:50 p.m. RN-B confirmed there were no skin assessment progress notes for R1 on 2/17/21, 2/24/21, and 3/3/21. RN-B verified it was their shift when these misses occurred. RN-B stated they are not aware of what R1's skin looks like currently and cannot speak to how R1's skin looked during those missing dates due to the nature of R1's rash changing "all the time".

When interviewed on 3/11/21, at 10:15a.m. assistant director of nursing (ADON) stated it was expected for residents to have skin assessments performed and documented weekly with their baths. Documentation of the assessments should happen during the shift the assessment was completed. The ADON also stated if skin concerns were found, the staff should involve the provider and nurse manager. All skin complications are discussed daily in rounds.

When interviewed on 3/11/21, at 12:15 p.m. NP-A stated she had assessed R1's skin on 2/16/21, but did not assess R1's rash since R1's return from the hospital on 3/5/21. NP-A verified at last visit on 3/8/21, R1 was sitting up in the chair and did not want to get back to bed. NP-A stated she relied on nursing staff to communicate changes in R1's skin. NP-A stated most of the communication was in person or through a page. NP-A's understanding was R1's rash was the same as it was before hospitalization. NP-A

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F 684	Continued From page 5 stated this was what nursing had indciated earlier in the week. NP-A verified incontinence can aggravate the rash on R1's bottom and thighs. It was the expectation of NP-A stated it was her expectation that with all incontinent care, skin was noted by the nursing assistant and told to the nurse if skin does not look right. On 3/11/21, the facility's skin monitoring policy was requested and was not provided.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 5, 2021

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

RE: CCN: 245518
Cycle Start Date: March 11, 2021

Dear Administrator:

On April 27, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us