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 Therefore, the NATCEP prohibition is rescinded.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

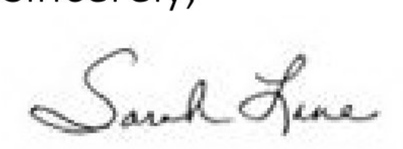
Re: Reinspection Results
Event ID:  2XEH12

Dear Administrator:

On January 23, 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 December 28, 2023.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Electronically delivered
January 8, 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 December 28, 2023, a survey was completed at your facility by the Minnesota Department of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Freeman Building
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 March 28, 2024 (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 June 28, 2024 (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

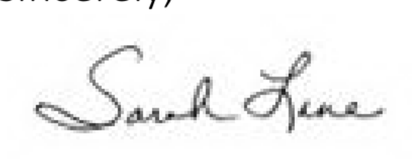
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



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| 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 12/28/2023 |

| 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 000 | INITIAL COMMENTS<br><br>On 12/21/23 through 12/28/23, a standard abbreviated survey was conducted at your facility. 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. H55188049C(MN99391) with a deficiency issued at F656 and F580.<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 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 that substantial compliance with the regulations has been attained. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or | F 580 | | 1/19/24 |

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

Electronically Signed | 01/10/2024

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 580 | Continued From page 1<br>clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to notify a resident | F 580 | It is the policy of Saint Therese of New Hope to ensure that residents□ providers | |

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| F 580 | Continued From page 2<br>consulting urologist and medical provider group for 1 of 3 residents (R1) when he missed eight antibiotic doses while being treated for a urinary tract infection (UTI).<br><br>R1's Minimum Data Set (MDS) dated 11/1/23, indicated he had moderate cognitive impairment, heart, and end stage kidney disease. He did not exhibit any behaviors, nor refuse care from staff, and needed extensive assistance from one nursing staff to get on and off the toilet.<br><br>R1's care plan dated 11/3/23, indicated he needed extensive assistance from one nursing staff every two to three hours to get on and off the toilet. The care plan did not identify a risk for developing a UTI, bladder scan requirements, and when to drain his bladder with at catheter.<br><br>R1's urology visit note dated 11/30/23, indicated R1 had only one kidney, and experienced an inability to completely empty his bladder when he urinated. During the visit R1 had over 800 cc (cubic centimeter) of urine in his bladder. The urinalysis indicated he had a UTI, and the antibiotic Keflex was prescribed for 10 days.<br><br>R1's November and December medical administration record (MAR) dated 11/30/23 through 12/10/23, indicated R1 received Keflex to treat a UTI.<br><br>R1's cystoscopy (a scope inserted into the bladder to examine urine and look for abnormalities) dated 12/7/23, indicated the pre-procedure urinalysis did not identify a UTI, but he found cloudy urine inside the bladder signaling an ongoing infection. | F 580 | and consulting providers are notified if they miss a dose of an antibiotic.<br><br>The notification of changes policy and procedure has been reviewed and it remains accurate.<br><br>R1 has not missed any further doses of antibiotics. Updates on resident□s condition has been communicated to urology.<br><br>All resident□s residing at Saint Therese that are prescribed antibiotics from an outside consulting provider have the potential to be affected.<br><br>All facility nurses have been re-educated on the notification of changes policy included in this are any missed doses of antibiotics ordered.<br><br>DON/Infection Preventionist/Designees to review antibiotic dosing Monday-Friday to verify that all antibiotic doses ordered were given and will review documentation to ensure that missed doses if any were communicated to the consulting provider as well as to the primary provider.<br><br>These audits will be reviewed at the monthly QAPI meetings for 3 months. QAPI will advise on direction or change as well as timeline for completion based on compliance.<br><br>The DON/Infection Preventionist/Designees are responsible for maintaining compliance with this | |

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| F 580 | Continued From page 3<br>R1's clinic referral document dated 12/7/23, came back with a new order to bladder scan once in the morning, second time between noon and 2:00 p.m., and last before he went to bed and to keep a record of their findings. If the volume of urine was greater than 250 cc staff would insert a catheter to drain his bladder.<br><br>R1's urology note dated 12/7/23, indicated he had a UTI and a new prescription of antibiotic Omnicef was sent to the pharmacy to be filled.<br><br>R1's licensed practical nurse (LPN)-A, from the urology provider, telephone encounter note dated 12/8/23 at 4:00 p.m., indicated she attempted to reach the nursing staff at St. Therese Home four times before she reached LPN-B. LPN-A gave a verbal order for a new antibiotic Omnicef to be taken once a day for 7 days and R1's FM-A already picked up the medication. In addition, LPN-A "reeducated" LPN-B regarding medical doctor (MD)-A's expectation to check for any urine residual left in his bladder after he urinated. If the amount of urine exceeded 250 cc the nurse needed to insert a catheter to drain the remaining urine. LPN-A instructed to document the amount of urine left in the bladder after he voided, and how much urine was drained out. LPN-A gave her the urology departments fax number so she could fax the results to MD-A.<br><br>R1's telephone order dated 12/8/23 indicated a new order for antibiotic Omnicef one pill every day for seven days.<br><br>R1's progress nursing note dated 12/8/23 at 9:41 p.m. indicated LPN-B received an order from the urologist to give him Omnicef for seven days and FM-A already picked up the medication from her | F 580 | requirement. | |

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| F 580 | Continued From page 4<br>pharmacy. The pill bottle only had five doses because FM-A gave two doses on 12/7/23 and 12/8/23. LPN-B attempted to reach LPN-A but the clinic was closed, she then updated the facility supervisor and left a message for the facility provider group to call back.<br><br>R1's progress nursing documentation dated 12/10/23 at 10:00 p.m. written by LPN-C indicated she scanned his bladder twice during her shift and both times inserted a catheter to drain the urine from his bladder.<br><br>R1's December MAR dated 12/11/23 through 12/15/23, indicated R1 received an antibiotic Omnicef once a day for seven days for an unresolved UTI diagnosed on 11/30/23. R1's FM-A filled the prescription and gave him a dose on 12/7/23 and 12/8/23. He missed two doses from 12/9/23 through 12/10/23. The medication resumed on 12/11/23 through 12/15/23.<br><br>R1's progress nursing note dated 12/11/23 at 5:17 p.m., indicated the facility nurse practitioner (NP)-A gave an order to give him the Omnicef for five days.<br><br>R1's medical order dated 12/11/23 indicated NP-A said it was "OK" to give the Omnicef from FM-A's supply.<br><br>R1's progress nursing note dated 12/12/23, at 11:36 p.m. indicated he "refused" to have his bladder scanned, and catheterization to drain the remaining urine from the bladder.<br><br>R1's progress nursing noted dated 12/13/23 at 6:34 a.m. indicated he urinated 125 cc, and the bladder scan identified 330 cc of urine remained | F 580 | | |

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| F 580 | Continued From page 5<br>in his bladder. He was catheterized and drained 250 cc cloudy yellow urine. He denied having an urge to empty his bladder even when it was full.<br><br>R1's NP visit note dated 12/15/23, indicated he had a cystoscopy on 12/8/23, showing the urine in his bladder was cloudy, and full of sediment indicating a UTI.<br><br>R1's order date 12/15/23, indicated NP-A ordered "it is mandatory" for bladder scans three times a day, and if the volume was greater than 250 cc insert a catheter to drain his bladder. In addition, staff was ordered to collect a urine specimen on 12/18/23.<br><br>R1's new prescription summary dated 12/20/23, sent from the pharmacy to the facility after the facility requested the antibiotic Omnicef prescription written on 12/15/23.<br><br>R1's December MAR dated 12/21/23 through 12/25/23, indicated R1 received an additional five days of the antibiotic Omnicef. The medication was ordered to start on 12/15/23 through 12/19/23 but was not recognized by the facility until 12/21/23 resulting in a delay of treatment for six days.<br><br>R1's NP-A's visit note dated 12/21/23, indicated R1 stated the staff were scanning his bladder for residual urine after he urinated. He was unable to remember how many times a day the staff inserted a catheter to drain his bladder. R1 had a new order for seven days of Omnicef, but the staff did not know if it was a new order, or a duplicate order. Urology confirmed the antibiotic Omnicef was a new order and urology would continue to manage his UTI. | F 580 | | |

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| F 580 | Continued From page 6<br><br>R1's medical order dated on 12/21/23 indicated NP-A order an antibiotic Omnicef once a day for five days "extended."<br><br>R1's facility medical provider's progress note dated 12/24/23 at 6:27 p.m., indicated he was having thick white urine and they found 400 cc of urine in the bladder at 10:00 p.m. and catheterized him for 250 cc of "thick whitish urine."<br><br>R1's progress nursing note on 12/24/23 at 9:21 p.m. indicated he still had a "cloudy/milky" urine. R1 did not complain of pain.<br><br>R1's progress nursing note dated 12/25/23 at 9:17 p.m. indicated he had increased confusion, and forgetful. The facility medical group was notified and the afterhours triage nurse instructed to keep monitoring him, and encourage him to drink more fluids. She updated NP-A, FM-A, and the house supervisor.<br><br>R1's urine culture results dated 12/26/23, at 11:25 a.m. indicated he had a urinary tract infection.<br><br>During interview on 12/26/23 at 12:41 p. family member (FM)-A stated on 12/7/23, she took her father to a urology appointment to have a cystoscopy procedure. During the procedure MD-A told her one still had a UTI and he recommended a new antibiotic to treat the infection. She worried if he would get the antibiotic that night so she had the prescription filled at her pharmacy. When she arrived back at the facility, she said she could not find any staff, so she gave him the first dose and kept the | F 580 | | |

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| F 580 | Continued From page 7 | F 580 | | |

medication and left the facility. On 12/8/23, she returned to the facility and while she gave R1 the second dose a nurse saw her and wanted to know what was going on and ask her what she gave her father. FM-A explained it was his antibiotic. On 12/15/23, she called MD-A because her father was continuing to have burning sensation and pain when he urinated. The urology clinic told her they would continue with the Omnicef for five more days. When she arrived at the facility on 12/19/23, she asked the nurse working if he received his antibiotic. The nurse said he did not have an order for any antibiotics. The nurse found a card containing the Omnicef amongst his medication that was unused.

During interview on 12/26/23 at 1:53 p.m. LPN-A stated that she had been with MD-A during all of his visits in November and December. she said on 11/30/23, R1 examined related to unable to empty his bladder completely, and a burning sensation when he urinated. The urine analysis indicated a UTI And he was sent back to the nursing facility with an antibiotic order for Keflex. R1 came back to the office on 12/7/23, for a scheduled cystoscope. Despite his urine test indicated no infection, during the procedure MD-A observed the urine in his bladder was cloudy indicating the UTI did not resolve. MD-A ordered Omnicef for seven days. LPN-A stated on 12/8/23, FM-A called her office regarding the facility not giving R1 his antibiotic. She called LPN-B and told her to give the Omnicef.

During interview 12/26/23 at 2:32 p.m. LPN-B stated R1's FM-A she phoned out he was on an antibiotic when she walked into the room and saw his FM-A give him a pill. She told FM-A she was

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| | 245518 | A. BUILDING _____ B. WING _____ | C 12/28/2023 |

| 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 580 | Continued From page 8<br>unable to give the antibiotic until she had a doctor's order. She said she attempted to reach the urology clinic on 12/8/23, but it was closed she then called the facilities Medical Group and left a message for the on call provider to call her back. LPN-B stated had FM-A let the facility fill the antibiotic prescription he would have received a dose that evening when it was ordered either through the pharmacy or through their emergency medication supply. On 12/8/23 at the end of her evening shift she told the oncoming staff the antibiotic order needed to be clarified by a medical provider. She was off for two days and when she came back to work her manager asked her about the antibiotic ordered on 12/7/23. LPN-B stated her manager instructed her to call the facility Medical Group to get further instructions NP-A ordered. NP-A ordered the staff to finish using the Omnicef from the 12/7/23 bottle.<br><br>During interview on 12/26/23 at 3:45 p.m., the director of nursing (DON) stated on 12/22/23, the ombudsman called her to discuss the missing antibiotic doses. She stated on 12/8/23, the facility received an order from MD-A regarding the Omnicef but after the phone call the nurse realized he was still on Keflex and wanted to verify if it was ok to give him both antibiotics. When she called back the urology clinic was closed. In addition, the facilities medical provider group was called but no one from the group called back.<br><br>During interview on 12/27/23 at 9:05 a.m. pharmacist (PH)-A stated on 12/7/23, they received prescription for Omnicef from MD-A. During the process of filling the prescription the computer system indicated the prescription was | F 580 | | |

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| F 580 | Continued From page 9<br>already filled at another pharmacy, so the order was canceled. He was not aware of the two missing dose on 12/9/23 through 12/10/23. He stated on 12/15/23, they received a new order for Omnicef from the urologist. The pharmacy filled the medication request and sent it to the facility. He stated sometimes when they get an order from a consulting physician the facility does not receive the prescription. According to their fax log the new Omnicef order was faxed to the facility on 12/15/23. In addition, the records indicated on 12/20/23 at 12:20 p.m. The facility reached out to his technician requesting the 12/15/23 antibiotic order. They attempted to fax it several times but the line was busy and they did not get through until the next day on 12/21/23. He was concerned to hear the facility did not react for five days after they received antibiotics from the pharmacy. According to his documents, R1 received Keflex from 11/30/23 through 12/9/23. Omnicef was ordered from 12/7/23 through 12/11/23, and when the UTI remained, the urologist ordered another 5 days of Omnicef to be given from 12/15/23 through 12/19/23. He stated the reason for the continued UTI was related to the eight missed doses.<br><br>During interview on 12/27/23 nurse practitioner (NP)-A stated she was contacted by LPN-B regarding the antibiotic ordered on 12/7/23 and R1 missed two doses. She stated she told the staff if they had an order for an antibiotic, they should have given it. In addition, being needed to tell the urologist he missed two doses of the antibiotic what to do next. She told the nursing staff urology will continue to follow and mange his urine output, and his antibiotic orders. NP-A Stated she had reviewed the urologist visit notes and also wrote an order for the staff to check the | F 580 | | |

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| F 580 | Continued From page 10<br>amount of urine left in his bladder after urinating and follow the urologists' orders and recommendations.<br><br>During interview on 12/27/23 at 4:14 p.m. R1 stated he has trouble urinating completely and not feeling the urge to urinate. He was happy with the care he received at the facility and regarding the missed antibiotic doses he was upset because FM-A was upset. He said things happen and they usually straighten out at the end. He said he feels burning when urinating and it has been going on the whole month of December. He said he would have only told the staff about the burning sensation if they asked if he was having symptoms. He said he always tells FM-A how he is feeling because she will let the staff know. He told FM-A about four or five days earlier his urine looked like milk for about four to five days but since then the issue resolved. He said he had never refused to have his bladder scanned or a catheterization.<br><br>During interview on 12/28/23 at 9:30 a.m., LPN-A was not aware of eight missed doses of Omnicef and thought R1 received his antibiotics on time as ordered by MD-A. She stated the missed doses probably cause the UTI to continue even after three courses of antibiotics. LPN-A stated the facility never called them regarding any antibiotic missing doses, or if he could receive Keflex and Omnicef at the same time. She received a phone call from the facility on 12/8/23 regarding the Omnicef ordered on 12/7/23. She instructed them to continue giving the antibiotic as it was ordered. She added if the facility called after hours, they would have the option to call the on-call triage nurse to address any concerns. She stated on 12/7/23, R1's urine analysis was negative but | F 580 | | |

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| F 580 | Continued From page 11<br>MD-A ordered another course of antibiotics because of the urine he saw in the bladder looked infected. The next call they received on 12/15/23, from FM-A telling them he still had pain and burning with urination. The urology clinic triage nurse sent a My Chart message to FM-A. The triage nurse left a message for the nursing staff to return a phone call, but they never did. She added antibiotics do not work if the doses are skipped or delayed.<br><br>During interview on 12/28/23, at 11:21 a.m. the DON was not aware R1's urology clinic had 24 hour service to answer any question or concern. She was unable to identify why the facility's on-call provider did not call them back on 12/8/23 to clarify if R1 could take two different antibiotics. She was not concerned because R1 was already on Keflex and since the 12/7/23 oncology report did not identify a UTI. She did confirm the document in question was not in R1's chart until they requested it on 12/27/23. In addition, she did not expect the staff to contact the urology staff with questions or concerns because FM-A told the staff she already spoke with them. Regarding the additional Omnicef doses sent to the pharmacy on 12/15/23, she said she did not know if the nurse or house supervisor accepted the medication and placed it in the medication cart. As the nurse reviewed the MAR since there was no order, they most likely did not know it was there because they only looked for the medication ordered. The DON would have expected R1's risk for UTI, along with the bladder scanning and catheterizing would have been on the care plan.<br><br>Facility policy Notification of Change dated 4/1/22, indicated the facility staff wood update the medical provider, the residence representative | F 580 | | |

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| F 580 | Continued From page 12<br>anytime there was a change in status. a clinical complication would include reoccurring UTIs. In addition, any circumstance involving a new treatment or the discontinuation of a treatment would require notification to the provider.<br><br>Facility policy Consulting Physician/Practitioner orders dated 4/1/22, indicated any time the facility received an order from a consulting provide, they would verify the order with the facility medical provider. | F 580 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the | F 656 | | 1/19/24 |

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| F 656 | Continued From page 13<br>findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents R1 when his care plan did not identify risks, goals, and interventions to address his chronic kidney failure, chronic kidney infection, urinary retention, post void residual bladder scan (a scanning device to show how much urine was left in the bladder after he urinated), and intermittent catheterization (a catheter inserted into the bladder to drain a buildup of urine.)<br><br>R1's Minimum Data Set (MDS) dated 11/1/23, indicated he had moderate cognitive impairment, heart, and end stage kidney disease. He did not exhibit any behaviors, nor refuse care from staff, and needed extensive assistance from one | F 656 | It is the policy of Saint Therese of New Hope to ensure that staff develops and implements a comprehensive care plan for all residents.<br><br>The Comprehensive Care plan policy and procedure has been reviewed and remains accurate.<br><br>R1□s chronic kidney failure care plan has been amended and identifies risks and goals; Interventions include but are not limited to, post void residual bladder scans, medications, and intermittent catheterization.<br><br>All residents residing at Saint Therese that | |

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| F 656 | Continued From page 14<br>nursing staff to get on and off the toilet.<br><br>R1's November and December medical administration record (MAR) dated 11/30/23 through 12/10/23, indicated R1 received Keflex to treat a UTI.<br><br>R1's urology visit note dated 11/30/23, indicated R1 had only one kidney, and experienced an inability to completely empty his bladder when he urinated. During the visit R1 had over 800 cc (cubic centimeter) of urine in his bladder. The urinalysis indicated he had a UTI, and the antibiotic Keflex was prescribed for 10 days.<br><br>R1's clinic referral document dated 12/7/23, came back with a new order to bladder scan once in the morning, second time between noon and 2:00 p.m., and last before he went to bed and to keep a record of their findings. If the volume of urine was greater than 250 cc staff would insert a catheter to drain his bladder.<br><br>R1's nursing documentation dated 12/10/23 at 10:00 p.m. written by LPN-C indicated she scanned his bladder twice during her shift and both times inserted a catheter to drain the urine from his bladder.<br><br>R1's December MAR dated 12/11/23 through 12/15/23, indicated R1 received Omnicef for an unresolved UTI diagnosed on 11/30/23.<br><br>R1's order date 12/15/23, indicated NP-A ordered "it is mandatory" for bladder scans three times a day, and if the volume was greater than 250 cc insert a catheter to drain his bladder. In addition, staff was ordered to collect a urine specimen on 12/18/23. | F 656 | have a chronic kidney failure with chronic kidney infections and urinary retention have the potential to be affected.<br><br>Nurse Managers and MDS Coordinators have been re-educated on development and implementation of a comprehensive care plan for residents with Chronic kidney failure to include identifying risks, developing goals, and identifying interventions on the care plan that reflects current treatment plan.<br><br>DON/Designees to audit (5) plans of care weekly to ensure that a comprehensive care plan is developed and implemented for the residents residing at Saint Therese. Areas of auditing to include a problem, identified risks, goals, and current interventions.<br><br>These audits will be reviewed at the monthly QAPI meetings for 3 months. QAPI will advise on direction or change as well as timeline for completion based on compliance.<br><br>The DON/Designees are responsible for maintaining compliance with this requirement. | |

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| F 656 | Continued From page 15<br><br>R1's December MAR dated 12/21/23 through 12/25/23, indicated R1 received an additional 5 days of Omnicef.<br><br>R1's care plan dated 11/3/23, indicated he needed extensive assistance from one nursing staff every two to three hours to get on and off the toilet. The care plan reviewd on 12/26/23, did not identify any risk for developing a UTI, bladder scan requirements, and when to drain his bladder with at catheter.<br><br>During interview on 12/28/23, at 11:21 a.m. the director of nursing (DON) stated she would have expected R1's risk for UTI, along with the bladder scanning and catheterizing would have been on the care plan.<br><br>Requested a facility policy regarding post void volumes, intermittent catheterization, and care plan development. None were provided. | F 656 | | |

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

Electronically delivered
January 8, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 2XEH11

Dear Administrator:

The above facility was surveyed on December 21, 2023 through December 28, 2023 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.

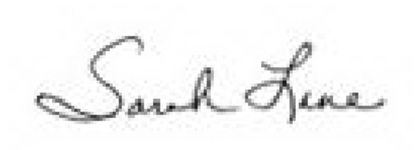
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Freeman Building
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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,



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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| 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 12/21/23 through 12/28/23, a complaint 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 licensing order(s) (was/were) issued. Please indicate in your electronic plan of | 2 000 | | |

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| 2 000 | Continued From page 1<br>correction you have reviewed these orders and identify the date when they will be completed.<br><br>The following complaints were reviewed. H55188049C(MN99391) with a licensing order issued at 0265 and 0565<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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction.<br>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/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 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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>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. | 2 000 | | |
| 2 265 | MN Rule 4658.0085 Notification of Chg in Resident Health Status<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:<br><br>A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;<br><br>C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; | 2 265 | | 1/19/24 |

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| 2 265 | Continued From page 3<br>D. a decision to transfer or discharge the resident from the nursing home; or<br><br>E. expected and unexpected resident deaths.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interview and document review, the facility failed to notify a resident consulting urologist and medical provider group for 1 of 3 residents (R1) when he missed eight antibiotic doses while being treated for a urinary tract infection (UTI).<br><br>R1's Minimum Data Set (MDS) dated 11/1/23, indicated he had moderate cognitive impairment, heart, and end stage kidney disease. He did not exhibit any behaviors, nor refuse care from staff, and needed extensive assistance from one nursing staff to get on and off the toilet.<br><br>R1's care plan dated 11/3/23, indicated he needed extensive assistance from one nursing staff every two to three hours to get on and off the toilet. The care plan did not identify a risk for developing a UTI, bladder scan requirements, and when to drain his bladder with at catheter.<br><br>R1's urology visit note dated 11/30/23, indicated R1 had only one kidney, and experienced an inability to completely empty his bladder when he urinated. During the visit R1 had over 800 cc (cubic centimeter) of urine in his bladder. The urinalysis indicated he had a UTI, and the antibiotic Keflex was prescribed for 10 days.<br><br>R1's November and December medical administration record (MAR) dated 11/30/23 through 12/10/23, indicated R1 received Keflex to | 2 265 | It is the policy of Saint Therese of New Hope to ensure that residents□ providers and consulting providers are notified if they miss a dose of an antibiotic.<br><br>The notification of changes policy and procedure has been reviewed and it remains accurate.<br><br>R1 has not missed any further doses of antibiotics. Updates on resident□s condition has been communicated to urology.<br><br>All resident□s residing at Saint Therese that are prescribed antibiotics from an outside consulting provider have the potential to be affected.<br><br>All facility nurses have been re-educated on the notification of changes policy included in this are any missed doses of antibiotics ordered.<br><br>DON/Infection Preventionist/Designees to review antibiotic dosing Monday-Friday to verify that all antibiotic doses ordered were given and will review documentation to ensure that missed doses if any were communicated to the consulting provider as well as to the primary provider. | |

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| 2 265 | Continued From page 4<br>treat a UTI.<br><br>R1's cystoscopy (a scope inserted into the bladder to examine urine and look for abnormalities) dated 12/7/23, indicated the pre-procedure urinalysis did not identify a UTI, but he found cloudy urine inside the bladder signaling an ongoing infection.<br><br>R1's clinic referral document dated 12/7/23, came back with a new order to bladder scan once in the morning, second time between noon and 2:00 p.m., and last before he went to bed and to keep a record of their findings. If the volume of urine was greater than 250 cc staff would insert a catheter to drain his bladder.<br><br>R1's urology note dated 12/7/23, indicated he had a UTI and a new prescription of antibiotic Omnicef was sent to the pharmacy to be filled.<br><br>R1's licensed practical nurse (LPN)-A, from the urology provider, telephone encounter note dated 12/8/23 at 4:00 p.m., indicated she attempted to reach the nursing staff at St. Therese Home four times before she reached LPN-B. LPN-A gave a verbal order for a new antibiotic Omnicef to be taken once a day for 7 days and R1's FM-A already picked up the medication. In addition, LPN-A "reeducated" LPN-B regarding medical doctor (MD)-A's expectation to check for any urine residual left in his bladder after he urinated. If the amount of urine exceeded 250 cc the nurse needed to insert a catheter to drain the remaining urine. LPN-A instructed to document the amount of urine left in the bladder after he voided, and how much urine was drained out. LPN-A gave her the urology departments fax number so she could fax the results to MD-A. | 2 265 | These audits will be reviewed at the monthly QAPI meetings for 3 months. QAPI will advise on direction or change as well as timeline for completion based on compliance.<br><br>The DON/Infection Preventionist/Designees are responsible for maintaining compliance with this requirement. | |

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| 2 265 | Continued From page 5<br><br>R1's telephone order dated 12/8/23 indicated a new order for antibiotic Omnicef one pill every day for seven days.<br><br>R1's progress nursing note dated 12/8/23 at 9:41 p.m. indicated LPN-B received an order from the urologist to give him Omnicef for seven days and FM-A already picked up the medication from her pharmacy. The pill bottle only had five doses because FM-A gave two doses on 12/7/23 and 12/8/23. LPN-B attempted to reach LPN-A but the clinic was closed, she then updated the facility supervisor and left a message for the facility provider group to call back.<br><br>R1's progress nursing documentation dated 12/10/23 at 10:00 p.m. written by LPN-C indicated she scanned his bladder twice during her shift and both times inserted a catheter to drain the urine from his bladder.<br><br>R1's December MAR dated 12/11/23 through 12/15/23, indicated R1 received an antibiotic Omnicef once a day for seven days for an unresolved UTI diagnosed on 11/30/23. R1's FM-A filled the prescription and gave him a dose on 12/7/23 and 12/8/23. He missed two doses from 12/9/23 through 12/10/23. The medication resumed on 12/11/23 through 12/15/23.<br><br>R1's progress nursing note dated 12/11/23 at 5:17 p.m., indicated the facility nurse practitioner (NP)-A gave an order to give him the Omnicef for five days.<br><br>R1's medical order dated 12/11/23 indicated NP-A said it was "OK" to give the Omnicef from FM-A's supply.<br><br>R1's progress nursing note dated 12/12/23, at | 2 265 | | |

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| 2 265 | Continued From page 6<br><br>11:36 p.m. indicated he "refused" to have his bladder scanned, and catheterization to drain the remaining urine from the bladder.<br><br>R1's progress nursing noted dated 12/13/23 at 6:34 a.m. indicated he urinated 125 cc, and the bladder scan identified 330 cc of urine remained in his bladder. He was catheterized and drained 250 cc cloudy yellow urine. He denied having an urge to empty his bladder even when it was full.<br><br>R1's NP visit note dated 12/15/23, indicated he had a cystoscopy on 12/8/23, showing the urine in his bladder was cloudy, and full of sediment indicating a UTI.<br><br>R1's order date 12/15/23, indicated NP-A ordered "it is mandatory" for bladder scans three times a day, and if the volume was greater than 250 cc insert a catheter to drain his bladder. In addition, staff was ordered to collect a urine specimen on 12/18/23.<br><br>R1's new prescription summary dated 12/20/23, sent from the pharmacy to the facility after the facility requested the antibiotic Omnicef prescription written on 12/15/23.<br><br>R1's December MAR dated 12/21/23 through 12/25/23, indicated R1 received an additional five days of the antibiotic Omnicef. The medication was ordered to start on 12/15/23 through 12/19/23 but was not recognized by the facility until 12/21/23 resulting in a delay of treatment for six days.<br><br>R1's NP-A's visit note dated 12/21/23, indicated R1 stated the staff were scanning his bladder for residual urine after he urinated. He was unable to remember how many times a day the staff | 2 265 | | |

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| 2 265 | Continued From page 7<br><br>inserted a catheter to drain his bladder. R1 had a new order for seven days of Omnicef, but the staff did not know if it was a new order, or a duplicate order. Urology confirmed the antibiotic Omnicef was a new order and urology would continue to manage his UTI.<br><br>R1's medical order dated on 12/21/23 indicated NP-A order an antibiotic Omnicef once a day for five days "extended."<br><br>R1's facility medical provider's progress note dated 12/24/23 at 6:27 p.m., indicated he was having thick white urine and they found 400 cc of urine in the bladder at 10:00 p.m. and catheterized him for 250 cc of "thick whitish urine."<br><br>R1's progress nursing note on 12/24/23 at 9:21 p.m. indicated he still had a "cloudy/milky" urine. R1 did not complain of pain.<br><br>R1's progress nursing note dated 12/25/23 at 9:17 p.m. indicated he had increased confusion, and forgetful. The facility medical group was notified and the afterhours triage nurse instructed to keep monitoring him, and encourage him to drink more fluids. She updated NP-A, FM-A, and the house supervisor.<br><br>R1's urine culture results dated 12/26/23, at 11:25 a.m. indicated he had a urinary tract infection.<br><br>During interview on 12/26/23 at 12:41 p. family member (FM)-A stated on 12/7/23, she took her father to a urology appointment to have a cystoscopy procedure. During the procedure MD-A told her one still had a UTI and he recommended a new antibiotic to treat the | 2 265 | | |

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| 2 265 | Continued From page 8<br><br>infection. She worried if he would get the antibiotic that night so she had the prescription filled at her pharmacy. When she arrived back at the facility, she said she could not find any staff, so she gave him the first dose and kept the medication and left the facility. On 12/8/23, she returned to the facility and while she gave R1 the second dose a nurse saw her and wanted to know what was going on and ask her what she gave her father. FM-A explained it was his antibiotic. On 12/15/23, she called MD-A because her father was continuing to have burning sensation and pain when he urinated. The urology clinic told her they would continue with the Omnicef for five more days. When she arrived at the facility on 12/19/23, she asked the nurse working if he received his antibiotic. The nurse said he did not have an order for any antibiotics. The nurse found a card containing the Omnicef amongst his medication that was unused.<br><br>During interview on 12/26/23 at 1:53 p.m. LPN-A stated that she had been with MD-A during all of his visits in November and December. she said on 11/30/23, R1 examined related to unable to empty his bladder completely, and a burning sensation when he urinated. The urine analysis indicated a UTI And he was sent back to the nursing facility with an antibiotic order for Keflex. R1 came back to the office on 12/7/23, for a scheduled cystoscope. Despite his urine test indicated no infection, during the procedure MD-A observed the urine in his bladder was cloudy indicating the UTI did not resolve. MD-A ordered Omnicef for seven days. LPN-A stated on 12/8/23, FM-A called her office regarding the facility not giving R1 his antibiotic. She called LPN-B and told her to give the Omnicef. | 2 265 | | |

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| 2 265 | Continued From page 9<br><br>During interview 12/26/23 at 2:32 p.m. LPN-B stated R1's FM-A she phoned out he was on an antibiotic when she walked into the room and saw his FM-A give him a pill. She told FM-A she was unable to give the antibiotic until she had a doctor's order. She said she attempted to reach the urology clinic on 12/8/23, but it was closed she then called the facilities Medical Group and left a message for the on call provider to call her back. LPN-B stated had FM-A let the facility fill the antibiotic prescription he would have received a dose that evening when it was ordered either through the pharmacy or through their emergency medication supply. On 12/8/23 at the end of her evening shift she told the oncoming staff the antibiotic order needed to be clarified by a medical provider. She was off for two days and when she came back to work her manager asked her about the antibiotic ordered on 12/7/23. LPN-B stated her manager instructed her to call the facility Medical Group to get further instructions NP-A ordered. NP-A ordered the staff to finish using the Omnicef from the 12/7/23 bottle.<br><br>During interview on 12/26/23 at 3:45 p.m., the director of nursing (DON) stated on 12/22/23, the ombudsman called her to discuss the missing antibiotic doses. She stated on 12/8/23, the facility received an order from MD-A regarding the Omnicef but after the phone call the nurse realized he was still on Keflex and wanted to verify if it was ok to give him both antibiotics. When she called back the urology clinic was closed. In addition, the facilities medical provider group was called but no one from the group called back.<br><br>During interview on 12/27/23 at 9:05 a.m. pharmacist (PH)-A stated on 12/7/23, they | 2 265 | | |

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| 2 265 | Continued From page 10<br><br>received prescription for Omnicef from MD-A. During the process of filling the prescription the computer system indicated the prescription was already filled at another pharmacy, so the order was canceled. He was not aware of the two missing dose on 12/9/23 through 12/10/23. He stated on 12/15/23, they received a new order for Omnicef from the urologist. The pharmacy filled the medication request and sent it to the facility. He stated sometimes when they get an order from a consulting physician the facility does not receive the prescription. According to their fax log the new Omnicef order was faxed to the facility on 12/15/23. In addition, the records indicated on 12/20/23 at 12:20 p.m. The facility reached out to his technician requesting the 12/15/23 antibiotic order. They attempted to fax it several times but the line was busy and they did not get through until the next day on 12/21/23. He was concerned to hear the facility did not react for five days after they received antibiotics from the pharmacy. According to his documents, R1 received Keflex from 11/30/23 through 12/9/23. Omnicef was ordered from 12/7/23 through 12/11/23, and when the UTI remained, the urologist ordered another 5 days of Omnicef to be given from 12/15/23 through 12/19/23. He stated the reason for the continued UTI was related to the eight missed doses.<br><br>During interview on 12/27/23 nurse practitioner (NP)-A stated she was contacted by LPN-B regarding the antibiotic ordered on 12/7/23 and R1 missed two doses. She stated she told the staff if they had an order for an antibiotic, they should have given it. In addition, being needed to tell the urologist he missed two doses of the antibiotic what to do next. She told the nursing staff urology will continue to follow and mange his urine output, and his antibiotic orders. NP-A | 2 265 | | |

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| 2 265 | Continued From page 11<br><br>Stated she had reviewed the urologist visit notes and also wrote an order for the staff to check the amount of urine left in his bladder after urinating and follow the urologists' orders and recommendations.<br><br>During interview on 12/27/23 at 4:14 p.m. R1 stated he has trouble urinating completely and not feeling the urge to urinate. He was happy with the care he received at the facility and regarding the missed antibiotic doses he was upset because FM-A was upset. He said things happen and they usually straighten out at the end. He said he feels burning when urinating and it has been going on the whole month of December. He said he would have only told the staff about the burning sensation if they asked if he was having symptoms. He said he always tells FM-A how he is feeling because she will let the staff know. He told FM-A about four or five days earlier his urine looked like milk for about four to five days but since then the issue resolved. He said he had never refused to have his bladder scanned or a catheterization.<br><br>During interview on 12/28/23 at 9:30 a.m., LPN-A was not aware of eight missed doses of Omnicef and thought R1 received his antibiotics on time as ordered by MD-A. She stated the missed doses probably cause the UTI to continue even after three courses of antibiotics. LPN-A stated the facility never called them regarding any antibiotic missing doses, or if he could receive Keflex and Omnicef at the same time. She received a phone call from the facility on 12/8/23 regarding the Omnicef ordered on 12/7/23. She instructed them to continue giving the antibiotic as it was ordered. She added if the facility called after hours, they would have the option to call the on-call triage nurse to address any concerns. She stated on | 2 265 | | |

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| 2 265 | Continued From page 12<br><br>12/7/23, R1's urine analysis was negative but MD-A ordered another course of antibiotics because of the urine he saw in the bladder looked infected. The next call they received on 12/15/23, from FM-A telling them he still had pain and burning with urination. The urology clinic triage nurse sent a My Chart message to FM-A. The triage nurse left a message for the nursing staff to return a phone call, but they never did. She added antibiotics do not work if the doses are skipped or delayed.<br><br>During interview on 12/28/23, at 11:21 a.m. the DON was not aware R1's urology clinic had 24 hour service to answer any question or concern. She was unable to identify why the facility's on-call provider did not call them back on 12/8/23 to clarify if R1 could take two different antibiotics. She was not concerned because R1 was already on Keflex and since the 12/7/23 oncology report did not identify a UTI. She did confirm the document in question was not in R1's chart until they requested it on 12/27/23. In addition, she did not expect the staff to contact the urology staff with questions or concerns because FM-A told the staff she already spoke with them. Regarding the additional Omnicef doses sent to the pharmacy on 12/15/23, she said she did not know if the nurse or house supervisor accepted the medication and placed it in the medication cart. As the nurse reviewed the MAR since there was no order, they most likely did not know it was there because they only looked for the medication ordered. The DON would have expected R1's risk for UTI, along with the bladder scanning and catheterizing would have been on the care plan.<br><br>Facility policy Notification of Change dated 4/1/22, indicated the facility staff wood update the medical provider, the residence representative | 2 265 | | |

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| | 00261 | A. BUILDING: _____ B. WING _____ | C 12/28/2023 |

| 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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| 2 265 | Continued From page 13<br><br>anytime there was a change in status. a clinical complication would include reoccurring UTIs. In addition, any circumstance involving a new treatment or the discontinuation of a treatment would require notification to the provider.<br><br>Facility policy Consulting Physician/Practitioner orders dated 4/1/22, indicated any time the facility received an order from a consulting provide, they would verify the order with the facility medical provider.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 2 265 | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observations, interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents R1 when his care plan did not identify risks, goals, and interventions to address his chronic kidney | 2 565 | It is the policy of Saint Therese of New Hope to ensure that staff develops and implements a comprehensive care plan for all residents. | 1/19/24 |

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| 2 565 | Continued From page 14<br><br>failure, chronic kidney infection, urinary retention, post void residual bladder scan (a scanning device to show how much urine was left in the bladder after he urinated), and intermittent catheterization (a catheter inserted into the bladder to drain a buildup of urine.)<br><br>R1's Minimum Data Set (MDS) dated 11/1/23, indicated he had moderate cognitive impairment, heart, and end stage kidney disease. He did not exhibit any behaviors, nor refuse care from staff, and needed extensive assistance from one nursing staff to get on and off the toilet.<br><br>R1's November and December medical administration record (MAR) dated 11/30/23 through 12/10/23, indicated R1 received Keflex to treat a UTI.<br><br>R1's urology visit note dated 11/30/23, indicated R1 had only one kidney, and experienced an inability to completely empty his bladder when he urinated. During the visit R1 had over 800 cc (cubic centimeter) of urine in his bladder. The urinalysis indicated he had a UTI, and the antibiotic Keflex was prescribed for 10 days.<br><br>R1's clinic referral document dated 12/7/23, came back with a new order to bladder scan once in the morning, second time between noon and 2:00 p.m., and last before he went to bed and to keep a record of their findings. If the volume of urine was greater than 250 cc staff would insert a catheter to drain his bladder.<br><br>R1's nursing documentation dated 12/10/23 at 10:00 p.m. written by LPN-C indicated she scanned his bladder twice during her shift and both times inserted a catheter to drain the urine from his bladder. | 2 565 | The Comprehensive Care plan policy and procedure has been reviewed and remains accurate.<br><br>R1□s chronic kidney failure care plan has been amended and identifies risks and goals; Interventions include but are not limited to, post void residual bladder scans, medications, and intermittent catheterization.<br><br>All residents residing at Saint Therese that have a chronic kidney failure with chronic kidney infections and urinary retention have the potential to be affected.<br><br>Nurse Managers and MDS Coordinators have been re-educated on development and implementation of a comprehensive care plan for residents with Chronic kidney failure to include identifying risks, developing goals, and identifying interventions on the care plan that reflects current treatment plan.<br><br>DON/Designees to audit (5) plans of care weekly to ensure that a comprehensive care plan is developed and implemented for the residents residing at Saint Therese. Areas of auditing to include a problem, identified risks, goals, and current interventions.<br><br>These audits will be reviewed at the monthly QAPI meetings for 3 months. QAPI will advise on direction or change as well as timeline for completion based on compliance.<br><br>The DON/Designees are responsible for | |

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| 2 565 | Continued From page 15<br><br>R1's December MAR dated 12/11/23 through 12/15/23, indicated R1 received Omnicef for an unresolved UTI diagnosed on 11/30/23.<br><br>R1's order date 12/15/23, indicated NP-A ordered "it is mandatory" for bladder scans three times a day, and if the volume was greater than 250 cc insert a catheter to drain his bladder. In addition, staff was ordered to collect a urine specimen on 12/18/23.<br><br>R1's December MAR dated 12/21/23 through 12/25/23, indicated R1 received an additional 5 days of Omnicef.<br><br>R1's care plan dated 11/3/23, indicated he needed extensive assistance from one nursing staff every two to three hours to get on and off the toilet. The care plan reviewd on 12/26/23, did not identify any risk for developing a UTI, bladder scan requirements, and when to drain his bladder with at catheter.<br><br>During interview on 12/28/23, at 11:21 a.m. the director of nursing (DON) stated she would have expected R1's risk for UTI, along with the bladder scanning and catheterizing would have been on the care plan.<br><br>Requested a facility policy regarding post void volumes, intermittent catheterization, and care plan development. None were provided.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. | 2 565 | maintaining compliance with this requirement. | |

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| 2 565 | Continued From page 16<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days. | 2 565 | | |