Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 1, 2023

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

RE: CCN: 245518
Cycle Start Date: March 8, 2023

Dear Administrator:

On April 26, 2023, we notified you a remedy was imposed. On May 17, 2023 the Minnesota Department of Health 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 May 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 8, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 26, 2023, 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 June 8, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 13, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2023

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

Re: Reinspection Results
Event ID: XTZN12

Dear Administrator:

On April 26, 2023 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 March 8, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 22, 2023

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

RE: CCN: 245518
Cycle Start Date: March 8, 2023

Dear Administrator:

On March 8, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 8, 2023 (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 8, 2023 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 03/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/7/23 and 3/8/23, 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. The following complaints were reviewed. H55189015C (MN00091541 and MN00091368) with a deficiencies issued at F689 and F690. 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. 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively	F 689	F689 SS = D – Free of Accidents Hazards/Supervision/ Devises	4/21/23

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

Electronically Signed | 04/01/2023

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 689	Continued From page 1 assess each fall, identify, and comprehensively analyze causal factors for potential root cause for individualized interventions to mitigate risk for falls for 2 of 3 residents (R2 and R4). Further failed to implement fall interventions for 1 of 3 residents (R2). Findings include: R2's admission Minimum Data Set (MDS) dated 2/8/23, identified R2 had diagnoses that included fracture of left pubis, dementia, anxiety, and history of falls with injury. MDS further indicated that R2 has severe cognitive impairment and had history of falls prior to admission. R2 required extensive assist of two for transfers and extensive assist of 1 for locomotion on/off the unit. R2 had impaired range of motion (ROM) to both his lower extremities and used a wheelchair for mobility. Review of R2's care assessment area (CAA) for falls dated 2/15/23, indicated R2 was at risk for falls due to diagnoses of fall with fractured pubis, hearing loss, impaired cognition, and psychotropic medication use. R2 worked with physical therapy (PT) and occupational therapy (OT). Staff were to observe for changes in balance and mobility. R2's fall care plan revised on 2/15/23 indicated R1 was at risk for a fall and/or a fall related injury due to left pubis fracture, history of falls, and other medical diagnoses. The care plan included the fall care plan included the following interventions that were dated 2/3/23: -staff to anticipate needs as resident is unable to express need. Consider the 4 P's: pain, potty, positioning, and personal items.	F 689	It is the policy of Saint Therese of New Hope to ensure that residents' environment remains as free of accidents/hazards as is possible and that each resident receives adequate supervision and assistive devises to prevent accidents. The falls prevention policy and procedure has been reviewed and it remains accurate. R2 has been re-assessed for fall risk and the care plans and NAR assignment sheets have been updated with the appropriate interventions to minimize the likelihood of falls. Staff have been updated of those interventions through unit huddles. R4 discharged from facility on 3/15/23. All other residents have been re-assessed for potential risks for falls related to intrinsic and extrinsic factors per policy. Care plans updated to reflect the individualized assessments. All facility nursing staff re-educated on falls policy to include interventions and documentation of approaches to minimize the likelihood of falls for residents using an individualized approach and root cause analysis. DON/Designees to review resident falls in scheduled IDT meetings and unit huddles using a root cause analysis method to determine the best intervention for the resident fall, while ensuring that the interventions are individualized and in	

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F 689	Continued From page 2 -staff will assist by: -helping resident keep room free of clutter -placing the call light within reach before exiting room -keeping the bed in correct low position for the resident. R2's transfer care plan revised on 2/15/23 indicated R2 required assistance with transfers. The transfer care included the following interventions: -staff will use mechanical lift (Hoyer) for all transfers and two staff with assistance in transfers. Start date 2/2/23. -staff will remind resident of and adhere to a weight bearing restriction per provider. The restriction is non weight bearing to left leg. Start date 2/3/23 -staff will use a large sling with the ceiling lift/total lift. start date 2/8/23 R2's fall incident report dated 2/21/23, at 11:00 a.m. indicated R2 had an unwitnessed fall in the activity room with no injuries. Corresponding progress note dated 2/22/23, identified the root cause of the fall as R2 tried to stand up from his wheelchair, had dementia, impaired cognition, pelvic fracture, and had poor safety insight and weakness. R2's care plan was updated on 2/22/23 with the intervention of add anti-roll back breaks to his wheelchair. R2's fall incident report dated 3/5/23 at 8:30 a.m. identified R2 had witnessed fall when he attempted to stand on his own, lost balance, and fell onto his buttocks in the dining room. Corresponding progress note dated 3/6/23, indicated root cause of the fall was, R2	F 689	place immediately within the care plan and NAR assignment sheets to minimize the risk for further falls. Falls will be audited weekly to ensure plan is being followed. Weekly 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. DON/Designees are responsible for maintaining compliance with this requirement. Completion date for the plan is April 21st, 2023.	

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F 689	Continued From page 3 self-transferred, lost balance, poor safety insight, impaired cognition with low cognitive processing therapy (CPT), impulsive and stands up and down frequently from wheelchair. The intervention was to have therapeutic recreation (TR) department to do a "portrait of me" (listing of what resident likes to do to keep busy). R2's care plan was updated on 3/6/23 to include the directive for staff to complete the "portrait of me". Review of facilities care guide (abbreviated care plan for direct care staff) dated 3/8/23, was inconsistent with the care plan for transfer. The care guide directed staff R2 transferred with assist of one with slide board, and was non-ambulatory. During an Observation on 3/7/23 at 3:40 p.m. R2 sat on a couch in common area with other residents. R2 did not know what his name was when asked. A wheelchair near the couch had a name band that identified the chair belonged to R2. The wheelchair was not equipped with the anti-roll back breaks according to the care plan. During an observation on 3/8/23 at 8:50 a.m. R2 laid in bed awake, his call light was within reach. The wheelchair in the room did not have R2's name band and was equipped with anti-roll back breaks. During an interview on 3/8/23 at 8:52 a.m. NA-A, NA-B and registered nurse (RN)-A confirmed the presence of the anti-rollback breaks on R2's wheelchair. NA-A, NA-B, and RN-A all indicated they were not aware when the anti-roll back breaks were added to the wheelchair or was	F 689		

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F 689	Continued From page 4 given a different chair since 3/7/23. During an interview on 3/8/23, at 9:44 a.m. NA-B indicated R2 was assist of two for transfers with a slide board and transfer belt. R2 could not use the call light appropriately and was not able to make his needs known. Staff had to anticipate R2's needs. During an interview on 3/8/23, at 10:05 a.m. NA-A indicated R2 was extensive assist of two with slide board for transfers. NA-A stated an awareness of R2 falls, however did not know what caused R2 to fall. NA-A was not aware of R2's interventions to prevent falls. During an observation on 3/8/23, at 12:28 p.m. R2 sat in his wheelchair at a dining room table. R2 pushed himself self-away from table and attempted to stand-up. An unknown staff member wheeled R2 to the center of his room. The staff member left the room, leaving R2 alone. R2's call light was located near the head of the bed, which was out of R2's reach. Between 12:29 p.m. and 12:38 p.m. R2 attempted to stand up without staff assistance three times. At 12:39 p.m. surveyor alerted NA-B who was walking in the hallway that R2 was attempting to stand. NA-B and RN-A entered R2's room, assisted R2 to sit back down in his wheelchair. R2 was then pushed out of his room to the nursing station common area. During an interview on 3/8/23, at 12:40 p.m. NA-B stated R2 should not be left alone in his room unless he was in bed or his recliner. R2 should be in a common area for closer supervision because of his risk for falls (this intervention was not identified on R2's care plan or care guide).	F 689		

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F 689	Continued From page 5 During an interview on 3/8/23 at 12:48 p.m. registered nurse (RN)-A reviewed R2's fall incident reports and indicated they were not comprehensive. RN-A explained had the anti-roll back breaks been on R2's wheelchair on 3/5/23 it could have prevented R2 from falling. During an interview on 3/8/23 at 1:22 p.m. nurse manager (NM)-A stated she became aware this morning R2's anti-roll back breaks were not put per the care plan on 2/22/23 after R2 fell. NM-A explained the breaks were added this morning by maintenance. NM-A reviewed R2's fall incident reports. NM-A indicated the fall assessment and causal analysis for the 3/5/23 fall were not comprehensive because it was not identified R2's care plan for the anti-roll back breaks on his chair was not followed when the 3/5/23 fall occurred. NM-A stated having the breaks in place could have prevented R2's fall on 3/5/23. NM-A explained R2 should not be left alone in his room unless in bed or recliner and should be in common areas for increased supervision because of his impulsivity. NM-A reviewed R2's care plan; NM-A reported the intervention was not on the care plan and should be. During an interview on 3/8/23 at 3:00 p.m. director of nursing (DON) indicated after a fall occurred the interdisciplinary team (IDT) reviewed the fall, interventions were updated in the care plan during the meeting. reviewed R2's fall record. DON stated the expectation interventions were implemented at the time of fall and the care plan was kept up to date. R4 R4's diagnoses list printed on 3/8/23, included type 2 diabetes and history of falls.	F 689		

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F 689	Continued From page 6 R4's admission assessment dated 3/3/23, indicated R4's mobility was slightly limited but was able to make frequent though slight changes in body or extremity and position independently R4 required assist of one to two staff for ambulation and transfers. R4 had not had a fall within the past month but did have a fall in the past two to six months. R4 fall risk factors included incontinence. R4's fall care plan revised on 3/6/23, indicated R4 was at risk for a fall and/or fall related injury related to neuropathy, history of urinary tract infections, gout, and congestive hear failure. Fall interventions dated 3/4/23 included the following: -Staff will assist by: helping the resident keep the room free of clutter, having safe footwear in place for ambulation/transferring, placing the call light within reach before exiting the room, keeping the bed in the correct low position for the resident, and wearing gripper socks when up without shoes. -Staff will place the call light where the resident can reach it before exiting the room each time and ensure all personal belonging are within reach for the resident. R4's activities of daily living care plan revised on 3/6/23, directed staff of the following: -Ambulation: I require a limited assistance of one with ambulation. -Toileting: I require a limited staff assistance of one for toileting transfers with a two wheeled walker and transfer belt. R4 eliminatation care plan indicated R4 was incontinent of bowel and bladder and directed staff to encourage toileting upon rising, before and after meals, at bedtime, and upon request (dated 3/3/23). -Transfers: I require a limited staff assistance if	F 689		

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F 689	Continued From page 7 one for transfers using a two wheeled walker. Review of facilities care guide dated 3/8/23, was inconsistent with the care plan. The care guide indicated R4 was a transfer with two with large sling, ambulated with assist of two and staff to lay down in bed or recliner after dinner. R4's fall incident report dated 3/5/23 at 7:33 p.m. identified R4 had an unwitnessed fall without injury. R4 was found on the floor in her room with wheelchair behind her in the middle of the room. R4 stated that she was dosing and slid out of the chair and was incontinent. Corresponding progress notes dated 3/6/23 at 10:51 a.m. identified the root cause for fall was resident dozing off in wheelchair and slipped out. The intervention was directed staff to offer R4 to lay down after supper or to sit in her recliner. R4's care plan was updated with the aforementioned intervention on 3/6/23. R4' fall incident report dated 3/6/23 at 9:00 p.m. identified R4 had an unwitnessed fall in her bathroom. The report indicated R4 had reported she was trying to self-transfer back to her wheelchair from the toilet when she lost her balance and fell. Corresponding progress note dated 3/7/23 at 10:06 a.m. indicated the root cause for fall was resident impulsiveness, poor safety awareness, weakness, and recent urinary tract infection. The intervention was for staff to place a "Call don't fall" sign in R4's room. R4's care plan was updated with the aforementioned intervention on 3/7/23. R4's record did not include a comprehensive fall assessment/analysis as it was not evident R4's	F 689		

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F 689	Continued From page 8 toileting program was reviewed for appropriateness even though the assessment dated 3/3/23 identified R4 was at risk for falls related to incontinence. During an observation and interview on 3/8/23 at 9:10 a.m. R4 sat in her wheelchair in her room. R4 reported she had fallen twice since she had been admitted to the facility. The first fall she had slid out of her wheelchair and was not sure how. R4 explained the fall on 3/6/23, happened because she had to go to the bathroom and could not wait for staff to answer her call light and still had a little elbow pain. R4 indicated when she has to go she has to go, and 5-6 minutes to wait for someone was too long. R4 reported staff had not offered a toileting schedule upon admission or after the fall occurred. R4 stated staff did not have a routine for prompted voiding, if she had been on a planned schedule for toileting it would be helpful, and probably prevented her from falling. During an interview on 3/8/23 at 9:44 a.m. NA-B indicated R4 was extensive assist of two for transfers, has had a fall and the intervention in place was for R4 to use call light for staff to help her. R4 was working with therapies. During an interview on 3/8/23 at 10:05 NA-A indicated R4 was extensive assist of one for transfers with walker and transfer belt. She was able to bear weight and assist with transfers. During an interview on 3/8/23 at 3:00 p.m. director of nursing (DON) reviewed R4's fall record and indicated the fall was not comprehensively assessed/analyzed . DON indicated toileting should have been re-evaluated.	F 689		

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 03/08/2023

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

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F 689	Continued From page 9 It was her expectation documentation was accurate and staff needed to look at the whole picture not just the fall. Facility Fall Risk Assessment policy dated 4/1/22, included -A risk assessment will be completed by the nurse or designee upon admission, quarterly, or when a significant change is identified. -The risk assessment will contain the following components: identify environmental and individual risks, including the need for supervision and evaluate and analyze hazards and risks. Facility Fall Prevention Program dated 4/1/22, included -Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -The facility utilizes a standardized risk assessment for determining a resident's fall risk. -Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychosocial, cognitive status, or recent change in functional status.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		4/21/23

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F 690	Continued From page 10 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete a comprehensive bowel/bladder assessment and failed to develop individualized toileting schedule/program in order to improve, maintain, or reduce the risk for worsening bowel/bladder function for 1 of 1 resident (R2) reviewed for incontinence. Findings include: R2's admission Minimum Data Set (MDS) dated	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI It is the policy of Saint Therese of New Hope to ensure that residents receive comprehensive bowel and bladder assessment on admission and thereafter per RAI assessments to ensure that residents have an individualized toileting schedule/program to improve, maintain or reduce the risk for worsening bowel/bladder function.	

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F 690	Continued From page 11 2/8/23, indicated R2 had diagnoses of benign prostatic hypertrophy prostrate (BPH), and prostate cancer. The MDS further identified R2 had severe cognitive impairment. The MDS identified R2 required extensive assist of one for toileting and personal hygiene. The MDS further identified that R2 had a catheter. R2's admission assessment dated 2/2/23, indicated R2 was incontinent of bowel and bladder related to his cognitive impairment and decreased mobility, and had a urinary catheter. Also included the date of R2's last bowel movement. R2's Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 2/15/23, indicated R2 had the urinary catheter for acute urinary retention placed on 2/1/23 while in hospital. R2's care plan last revised on 2/15/23, indicated urinary catheter in place for prostate cancer and urinary retention, with the following interventions: -staff to change drainage bag to leg bag in the morning and overnight bag at bedtime. Start Date 2/3/23. -staff to monitor for signs and symptoms of urinary tract infection (UTI), provide catheter cares, and report urinary output to nurses each shift. Start date 2/3/23. R2's Care Guide (abbreviated care plan for direct care staff) dated 3/8/23, indicted R2 had a urinary catheter, with outputs to be reported and catheter cares competed on each shift. R2's progress note dated 2/27/23, indicated R2 pulled out his catheter.	F 690	R2 has had a comprehensive bowel and bladder assessment and the care plans and NAR assignment sheets have been updated with the appropriate individualized interventions. All other residents have been reviewed for presence of individualized bowel and bladder assessment per RAI manual and any identified to not have the comprehensive assessment have been assessed. All residents will have an individualized toileting plan to maintain or reduce the risk of worsening bowel and bladder function. Nursing staff re-educated on bowel and bladder policy to include interventions, to allow residents to maintain or reduce the risk for worsening bowel/bladder function. DON/Designees to audit residents during their assessment reference period to ensure that their bowel and bladder functions are assessed, and appropriate interventions are in place per resident individualized need. These audits will be done per the resident assessment list that is generated depending on their assessment reference date. 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. The DON/Designee is responsible for maintaining compliance with this	

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F 690	Continued From page 12 R2's progress note dated 2/28/23, indicated R2's catheter was discontinued after R2 pulling it out. R2 was voiding with no concerns. R2's progress note dated 3/2/23, included, resident has no catheter, can urinate on own. R2's record reviewed between 2/27/23 through 3/8/23, did not identify or include a comprehensive bladder assessment to ascertain type of incontinence if present, presence of urinary retention after discontinuation of catheter, and voiding routines for determination of an individualized toileting plan. Further, it was not evident the care plan was updated to reflect R2's voiding status. During an interview on 3/7/23 at 4:03 p.m., NA-D stated R2 was toileted every 1-2 hours. R2 required assistance of one with gait belt. During an interview on 3/8/23 at 9:44 a.m. NA-B stated R2 was extensive assist of two for toileting, was toileted daily at 9:00 a.m. for bowel movements and then every 2 hours, or if R2 seemed anxious. NA-B explained she knew what R2's toileting program was from the care guide. During an interview on 3/8/23 at 10:05 a.m. NA-A explained R2 was incontinent and used incontinent briefs. Further R2 was not able to make his needs known and did not use the call light appropraitely, so staff took R2 to the bathroom every two hours. NA-A would refer to the care guide if had questions about caring for a resident. During an interview on 3/8/23 at 12:48 p.m. RN-A	F 690	requirement. Completion date for the plan is April 21st, 2023.	

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F 690	Continued From page 13 stated upon admission R2 had a urinary catheter, however pulled it out. R2 had just completed a three day toileting assessment, but indicated an awareness of the results. RN-A explained the admission assessment was completed by the admissions nurse; the assessment included included the bowel and bladder assessment. Stated the facility relied on the report from the hospital to determine toileting program based on whether the resident was continent or incontinent. If the resident was incontinent the resident would be placed on an every two hour check and change program. RN-A explained the facility did not do their own bowel and bladder assessment to individualize a toileting plan upon admission. During an interview on 3/8/23 at 1:22 p.m. NM-A reviewed R2's record, indicated the record did not identify routine bladder assessments to determine if R2 had urinary retention. Further indicated R2 did not have a comprehensive bladder assessment after the catheter was discontinued and there was not an individualized toileting plan. NM-A also explained the care plan and care plan was not updated after the catheter was discontinued and should have been. During an interview on 3/8/23 at 3:00 p.m. with DON stated the bowel and bladder assessment done at the time of admission was comprehensive however agreed the assessment did not identify type of incontinence, risk factors for urinary/bowel incontinence, or the resident's usual toileting routines. Facility's Incontinence policy dated 4/1/22, indicated that the facility must ensure that residents that are incontinent of bladder and bowel will receive appropriate treatment to	F 690		

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F 690	Continued From page 14 prevent infections and to restore continence to the extent possible.	F 690		

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	00261	A. BUILDING: _____ B. WING _____	03/08/2023

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2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to complete a comprehensive bowel/bladder assessment and failed to develop individualized toileting schedule/program in order to improve, maintain, or reduce the risk for worsening bowel/bladder function for 1 of 1 resident (R2) reviewed for incontinence. Findings include: R2's admission Minimum Data Set (MDS) dated 2/8/23, indicated R2 had diagnoses of benign prostatic hypertrophy prostrate (BPH), and prostate cancer. The MDS further identified R2 had severe cognitive impairment. The MDS identified R2 required extensive assist of one for toileting and personal hygiene. The MDS further	2 910	It is the policy of Saint Therese of New Hope to ensure that residents receive comprehensive bowel and bladder assessment on admission and thereafter per RAI assessments to ensure that residents have an individualized toileting schedule/program to improve, maintain or reduce the risk for worsening bowel/bladder function. R2 has had a comprehensive bowel and bladder assessment and the care plans and NAR assignment sheets have been updated with the appropriate individualized interventions. All other residents have been reviewed for presence of individualized bowel and	4/21/23

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

Electronically Signed | 04/01/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 910	Continued From page 1 identified that R2 had a catheter. R2's admission assessment dated 2/2/23, indicated R2 was incontinent of bowel and bladder related to his cognitive impairment and decreased mobility, and had a urinary catheter. Also included the date of R2's last bowel movement. R2's Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 2/15/23, indicated R2 had the urinary catheter for acute urinary retention placed on 2/1/23 while in hospital. R2's care plan last revised on 2/15/23, indicated urinary catheter in place for prostate cancer and urinary retention, with the following interventions: -staff to change drainage bag to leg bag in the morning and overnight bag at bedtime. Start Date 2/3/23. -staff to monitor for signs and symptoms of urinary tract infection (UTI), provide catheter cares, and report urinary output to nurses each shift. Start date 2/3/23. R2's Care Guide (abbreviated care plan for direct care staff) dated 3/8/23, indicted R2 had a urinary catheter, with outputs to be reported and catheter cares competed on each shift. R2's progress note dated 2/27/23, indicated R2 pulled out his catheter. R2's progress note dated 2/28/23, indicated R2's catheter was discontinued after R2 pulling it out. R2 was voiding with no concerns. R2's progress note dated 3/2/23, included, resident has no catheter, can urinate on own.	2 910	bladder assessment per RAI manual and any identified to not have the comprehensive assessment have been assessed. All residents will have an individualized toileting plan to maintain or reduce the risk of worsening bowel and bladder function. Nursing staff re-educated on bowel and bladder policy to include interventions, to allow residents to maintain or reduce the risk for worsening bowel/bladder function. DON/Designees to audit residents during their assessment reference period to ensure that their bowel and bladder functions are assessed, and appropriate interventions are in place per resident individualized need. These audits will be done per the resident assessment list that is generated depending on their assessment reference date. 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. The DON/Designee is responsible for maintaining compliance with this requirement. Completion date for the plan is April 21st, 2023.	

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2 910	Continued From page 2 R2's record reviewed between 2/27/23 through 3/8/23, did not identify or include a comprehensive bladder assessment to ascertain type of incontinence if present, presence of urinary retention after discontinuation of catheter, and voiding routines for determination of an individualized toileting plan. Further, it was not evident the care plan was updated to reflect R2's voiding status. During an interview on 3/7/23 at 4:03 p.m., NA-D stated R2 was toileted every 1-2 hours. R2 required assistance of one with gait belt. During an interview on 3/8/23 at 9:44 a.m. NA-B stated R2 was extensive assist of two for toileting, was toileted daily at 9:00 a.m. for bowel movements and then every 2 hours, or if R2 seemed anxious. NA-B explained she knew what R2's toileting program was from the care guide. During an interview on 3/8/23 at 10:05 a.m. NA-A explained R2 was incontinent and used incontinent briefs. Further R2 was not able to make his needs known and did not use the call light appropraitely, so staff took R2 to the bathroom every two hours. NA-A would refer to the care guide if had questions about caring for a resident. During an interview on 3/8/23 at 12:48 p.m. RN-A stated upon admission R2 had a urinary catheter, however pulled it out. R2 had just completed a three day toileting assessment, but indicated an awareness of the results. RN-A explained the admission assessment was completed by the admissions nurse; the assessment included included the bowel and bladder assessment. Stated the facility relied on the report from the	2 910		

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2 910	Continued From page 3 hospital to determine toileting program based on whether the resident was continent or incontinent. If the resident was incontinent the resident would be placed on an every two hour check and change program. RN-A explained the facility did not do their own bowel and bladder assessment to individualize a toileting plan upon admission. During an interview on 3/8/23 at 1:22 p.m. NM-A reviewed R2's record, indicated the record did not identify routine bladder assessments to determine if R2 had urinary retention. Further indicated R2 did not have a comprehensive bladder assessment after the catheter was discontinued and there was not an individualized toileting plan. NM-A also explained the care plan and care plan was not updated after the catheter was discontinued and should have been. During an interview on 3/8/23 at 3:00 p.m. with DON stated the bowel and bladder assessment done at the time of admission was comprehensive however agreed the assessment did not identify type of incontinence, risk factors for urinary/bowel incontinence, or the resident's usual toileting routines. Facility's Incontinence policy dated 4/1/22, indicated that the facility must ensure that residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to comprehensive assessment of bowel and bladderto assure proper assessment and	2 910		

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2 910	Continued From page 4 interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: XTZN11

Dear Administrator:

The above facility was surveyed on March 7, 2023 through March 8, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us