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 Therefore, the NATCEP prohibition is rescinded.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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Electronically delivered

April 1, 2024

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

Re: Reinspection Results
Event ID: VNEY12

Dear Administrator:

On March 19, 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 February 12, 2024. At this time these correction orders were found corrected.

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
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February 27, 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 8, 2024, we informed you that we may impose enforcement remedies.

On February 12, 2024, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be 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.

REMEDIES

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

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

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 28, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have 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

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 02/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/9/24 through 2/12/24, 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. H55189604C (MN00100578) with a deficiency issued at F580 , F656 and F684. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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		3/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/11/2024

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 clinical complications); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of change in	F 580	It is the policy of Saint Therese of New Hope to ensure the facility promptly	

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F 580	Continued From page 2 condition for 1 of 3 (R1) reviewed for change of condition. Findings include R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R1 had severe cognitive impairment. R1 required set up assist for eating and oral care. R1 required substantial/maximal assist of one person to transfer chair to bed. R1's care plan dated 6/24/22, identified R1 was at a safety risk and may fall due to history of stroke with right sided weakness. R1 had a diagnosis of thrombocytopenia, hypertension, chronic heart failure, and dementia. Staff were to check on R1 regularly to try to anticipate R1's needs. Keep call light and commonly used items within reach. R1's nurse practitioner (NP) note dated 1/26/24, identified R1 was seen by NP due to testing positive for COVID-19 during routine testing on this day. R1 reported to generally not feel well, with symptom onset when awaking in the morning. Symptoms included cough, nasal congestion, body aches, and fatigue. Review of symptoms indicates R1's report was limited due to history of dementia. Assessment and plan directed nursing staff to notify provider with any change in patients condition. R1's vital signs between 1/26/24 and 2/5/24, were reviewed. It was not evident R1's vital signs were obtained on 2/5/24 nor evident of any assessments completed related acute illness.	F 580	informs the resident physician or the consulting physician. With residents (his / her) authority, the resident□s representative when there is a change requiring notification. The policy and procedure have been reviewed and it remains accurate. R1 has expired. All residents post-COVID at Saint Therese of New Hope have the potential to experience this deficient practice related to timely notification of providers and/or consulting providers of any change of conditions from baseline. All residents have been audited for changes in conditions from the baseline. Any change from the line has been communicated to the resident/resident□s representative / Provider. All facility nurses have been re-educated on the notification of changes in policy related the Notification process of any change in a resident from their baseline. DON/Infection Preventionist/Designees to audit resident nurses□ notes (Monday □ Friday) for 3 months and conduct weekend spot audits for any documentation of residents' change in condition from baseline. The audit will include a notification review per policy. These audits will be reviewed at the monthly QAPI meeting. QAPI will advise on direction or change to the timeline for completion based on compliance. The DON/Infection Preventionist/Designees are responsible for maintaining	

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F 580	Continued From page 3 During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24, her shift started at 7:00 a.m. and R1 wanted to get up around 8:00 a.m. NA-A recalled R1 to be weaker with tasks more than normal, required more assistance to transfer, and was leaning to one side more then the other. R1 required assist to wash her face, brush her teeth, and comb her hair and which was abnormal. NA-A reported R1 was typically more combative with cares, however was not that morning. After she finished R1 cares, NA-A reported to registered nurse (RN)-A R1 was weaker than normal. NA-A indicated RN-A explained to her R1 was just getting over Covid and did not take R1's vital signs. After cares R1 was taken to the dining room for breakfast. NA-A recalled R1 required assist to eat breakfast around 8:00 a.m.- 9:00 a.m. by RN-A which was also abnormal. R1 usually fed herself. During interview on 2/12/24 at 9:48 a.m., RN-A indicated her shift on 2/5/24, started at 6:00 a.m. and did not receive anything in report regarding R1. RN-A stated NA-A could have reported R1 was weaker than normal, however did not recall. RN-A recalled she assisted R1 with eating breakfast because she was tired and weak, but felt this was due to Covid symptoms. She did not feel there was any need to complete any further assessments, take vital signs, or notify the physician. RN-A returned from break at 12:10 p.m. and was immediately notified of concerns with R1. When RN-A saw R1 sitting at the table in the dining room, R1's lips were blue and appeared as though she had died. The first-time reporting concerns to nurse practitioner (NP)-A was a page at 12:20 p.m. NP-A called back right	F 580	compliance with this requirement.	

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F 580	Continued From page 4	F 580		

away, RN-A stated she told NP-A she was needed right away because R1 had died.

During interview on 2/12/24 at 11:54 a.m., NP-A indicated not receiving any communications on 2/5/23 on R1's status until receiving a page at 12:20 p.m. and a return call to RN-A at 12:21 p.m. NP-A indicated the expectation would be for facility staff to report changes to the provider if there were any concerns. If nursing assistants were to report increased weakness or inability to do things they could typically be able to do NP-A would expect to be notified. During subsequent interview on 2/12/24 at 2:58 p.m. NP-A was not notified of any fatigue, change or abnormal vitals since R1 was diagnosed with Covid and placed on quarantine on 1/26/24. Outside of R1's other co-morbidities R1 was rather stable from NP-A's knowledge. NP-A was not aware there were days R1's vitals and respiratory status was not assessed. NP-A would expect a report on any change of condition.

Policy and procedure titled notification of changes dated April 1st, 2022, identifies the purpose of the policy is to endure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.
Compliance guidelines:
The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.
Significant change in the resident's physical, mental or psychosocial condition such a deterioration in health, mental or psychosocial

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F 580	Continued From page 5 status. Death of a resident: The resident's physician is to be notified immediately in accordance with state law.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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 - (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 (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). (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 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/8/24

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F 656	Continued From page 6 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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the person-centered care plan for 1 of 1 residents (R1) reviewed for activities of daily living (ADL). Findings included: R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R1 had severe cognitive impairment. R1 required set up assist for eating and oral care. Personal hygiene is not completed. R1 required substantial/maximal assist of one person to transfer chair to bed. R1's care plan dated 6/24/22, identified R1 is at a safety risk and may fall due to history of stroke with right sided weakness. The care plan directed staff to check on R1 regularly to try to anticipate R1's needs. Keep call light and commonly used items within reach.	F 656	It is the policy of Saint Therese of New Hope to ensure that staff follows the comprehensive care plan for all residents. The Comprehensive Care plan policy and procedure has been reviewed and remains accurate. R1 has expired. All residents residing at Saint Therese that require assistance with repositioning have the potential to be affected. All resident identified as needing assistance with repositioning are being re-positioned per plan of care. Nurse Managers, Nurses, and CNAs have been re-educated on following resident□s comprehensive care plan in relation to repositioning. DON/Designees to audit (5) plans of care weekly to ensure that a comprehensive care plan is developed and implemented	

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F 656	Continued From page 7 R1's bowel and bladder care plan dated 6/26/22 directed staff to offer the bathroom when waking up, after breakfast, before and after lunch, before and after supper, night cares, night, and staff are to remind R1 before activities and as needed per R1's request. R1's care plan dated 12/26/23, identified R1 had ADL deficits and required assistance. The care plan directed staff to assist R1 with repositioning every two to three hours and as needed. During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24. Her shift started at 7:00 a.m. and R1 wanted to get up around 8:00 a.m. NA-A assisted R1 with morning cares. NA-A reported R1 went to the dining area following cares and was visualized in dining room around 8:00 a.m.- 9:00 a.m. From 9:00 a.m. to 11:15 a.m. NA-A was assisting other residents for the day and did not provide cares for R1. From 11:15 a.m. to 12:00 p.m. NA-A went on break. At 12:00 p.m. R1 was in the same location as she was last visualized at around 8:00 a.m. to 9:00 a.m. NA-A had not offered or assisted R1 to the bathroom or provide any further assistants. During interview on 2/12/24 at 10:23 a.m., NA-B indicated she worked the morning of 2/5/24. NA-B did not provide cares for R1 between breakfast and lunch. During interview on 2/9/24 at 10:31 a.m., NA-C indicated she worked the morning of 2/5/24. NA-C did not provide cares to R1 between breakfast and lunch. During interview on 2/12/24 at 9:48 a.m., registered nurse (RN)-A indicated her shift started	F 656	for the residents residing at Saint Therese. Areas of auditing to include a problem, identified risks, goals, and current interventions. 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/Designees are responsible for maintaining compliance with this requirement.	

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at 6:00 a.m. and did not receive anything in report regarding R1. RN-A assisted R1 with breakfast and visualized R1 between 9:00 a.m. and 10:00 a.m. as another resident was talking with R1. RN-A assisted on another hallway between 10:15 a.m. to 10:30 a.m. Between 10:45 a.m. to 11:35 a.m. RN-A was passing medication to other residents. From 11:35 a.m. to 12:10 p.m. RN-A was on break . RN-A did not provide cares or interact with R1 during this time.

During interview on 2/12/24 at 4:31 p.m., director of nursing (DON) and Administrator indicated R1's care plan was not followed and R1 went a prolonged period without being checked on. It was inappropriate for R1 to go two to three hours without being checked on and R1 should have been provided incontinence cares and offered to be turned/repositioned per R1's care plan.

Policy and procedure titled comprehensive care plans dated august 2022 indicates it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for

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F 656	Continued From page 9 carrying out the interventions, initially and when changes are made.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor after an acute change of condition related to increased weakness/fatigue was identified was identified for 1 of 3 residents (R1) reviewed for change of condition Findings include R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's provider orders for life-sustaining treatment (POLST) dated 6/16/22, identified cardiopulmonary resuscitation (CPR) should be attempted. Medical treatments indicated full treatment. Transfer to hospital and/or intensive care unit if indicated. R1's annual Minimum Data Set (MDS) dated 12/15/23, identified R1 was independent with	F 684	It is the policy of Saint Therese of New Hope to ensure that resident is comprehensively assessed, and their individualized needs care planed so they can receive treatment and care in accordance with professional standards of practice. The policy has been reviewed and remains accurate. R1 has expired. All residents residing at Saint Therese have the potential to be affected by this deficient practice. All residents have been re-assessed and their care plan reviewed to ensure individualized care. All Nurses have been re-educated on Effectively assessing residents for any changes to conclude weakness and/or fatigue. DON / Designees to review resident nurses□ notes (Monday □ Friday) for 3	3/15/24

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F 684	Continued From page 10 eating and oral care. R1 required partial to moderate assistance with personal hygiene. R1's cognition was not identified. R1's care plan dated 1/26/24 identified R1 was at risk for exposure of Covid infection due to residing in congregate living facility, co-morbid conditions, advanced age and dependency on caregiver assistance, R1 tested positive for Covid 1/26/24.Staff are to monitor for presence or absence of symptoms: fever, cough, shortness of breath, sore throat, fatigue, muscle/body aches, headache, new loss of taste or smell, congestion or runny noise, nausea or vomiting, diarrhea. R1's nurse practitioner (NP) note dated 1/26/24 identified R1 was seen by NP due to testing positive for Covid during routine testing on this day. R1 reported to generally not feel well, with symptom onset when awaking in the morning. Symptoms included cough, nasal congestion, body aches, and fatigue. Review of symptoms indicates R1's report was limited due to history of dementia. Assessment and plan directs for nursing staff to notify provider with any change in patients condition. Progress note dated 1/26/24, indicated R1's temperature was 98.4 with oxygen saturation (02) of 95% on room air. R1 had body aches, runny nose and congestion, and fatigue. Progress note dated 2/4/24, indicated R1 had poor meal intake per usual and encourage fluids. Temp was 97.5 and 02 saturations were 96% on room air. R1 did not have symptoms of cough/runny nose/congestion and denied fatigue. Lung sounds were clear.	F 684	months for any change in resident condition and ensure that resident is assessed and needs care planed and are met accordingly. These audits will be reviewed at the monthly QAPI meeting. QAPI will advise on direction or change to timeline for completion based on compliance. The DON / Designees are responsible for maintaining compliance with this requirement.	

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R1's vital signs reviewed between 1/26/24 through 2/4/24 and identified vital signs were not consistently monitored and/or assessed during her Covid illness. The record identified the following:
-Respiratory rate on 1/25/24 was 18 breaths per minute, on 2/1/24 respiratory rate was 16. No other entries were recorded.
-Pulse on 1/25/24 was 67 beats per minute (bpm), on 2/1/24 pulse was 64 bmp. No other entries were recorded.
-Blood pressures were recorded once daily between 1/25/24 through 2/4/24 and ranged between 133/60 (on 1/30/24) to 176/57 (1/26/24). Readings were seemingly not outside of R1's baseline.

R1's record did not have any recorded vital signs on 2/5/24, nor evident R1 had been provided toileting and/or repositioning after morning cares were completed. February medication administration record dated 2/5/24 indicated scheduled medication administration was documented as administered at 9:14 a.m.

R1's late entry progress note dated 2/5/24 for 12:20 p.m., included "[R1] who had elected full code status was noted by NARS [nursing assistants] sitting in her w/c [wheelchair] head slumped slightly down at the table. Per staff interview this is how resident often is waiting for her meals as she will nap while waiting for tray. Around 12:20 NAR went to give her the lunch tray and noted her to be unresponsive, blue, and cold to touch. Nurse was notified immediately by NAR. Nurse called NP, who was in building and immediately started chest compressions, the nurse on the floor to assigned to resident called 911. NP states that resident was blue, and Riga

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[sic] Mortis had started to set. She reported even though it was obvious she was deceased, she decided to complete 1 round of chest compressions." The note indicated R1 had died.

Ambulance record dated 2/5/24, identified paramedics were dispatched at 12:25 p.m. due to a cardiac arrest/death. Assessment included R1 presenting to EMS lying supine (face up) in bed. R1 was pulseless, apneic (involuntarily not breathing), and unresponsive. R1 was moved to floor. When moving patient, neck and shoulder were stiff and did not move normally when patient was moved. When R1 was placed on the floor R1's neck and head to not rest on the ground due to rigor. Due to R1's presentation with obvious signs of death, EMS estimates patient had a prolonged downtime. Due to obvious signs of death no further resuscitation efforts were performed.

During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24, her shift started at 7:00 a.m. R1 wanted to get up around 8:00 a.m. NA-A recalled R1 was weaker with tasks more then normal, was more difficult to transfer, and was leaning to one side more then the other. R1 required assist to wash her face, brush her teeth, and comb her hair, which was abnormal for R1. NA-A reported R1 was typically more combative with cares, however was not that morning. After she finished R1 cares, NA-A reported to registered nurse (RN)-A R1 was weaker than normal. NA-A indicated RN-A explained to her R1 was just getting over Covid and did not take R1's vital signs. After cares R1 was taken to the dining room for breakfast. NA-A recalled R1 required assist to eat breakfast

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around 8:00 a.m.- 9:00 a.m. by RN-A which was also abnormal. R1 usually fed herself. From 9:00 a.m. to 11:15 a.m. NA-A was assisting other residents for the day and did not provide cares for R1. From 11:15 a.m. to 12:00 p.m. NA-A went on break. At 12:00 p.m. NA-A returned to the floor and started to pass lunch trays. NA-A recalled R1 being in the same place from breakfast and R1's head was down. NA-A took R1's tray and brought it to R1 and noticed R1 was not responding. NA-A reported R1's hand was cold to touch and attempted to pick R1's hand up, but it dropped down. NA-A called for RN-A to look at R1. RN-A came over to assess R1 and told NA-A, R1 had passed away. NA-A then removed R1 from the dining room and took her back to her room. The nurse practitioner and emergency medical services were notified.

During interview on 2/9/24 at 10:56 a.m., R2 recalled R1 being at the dining table on 2/5/24 between 8:30 a.m. and 9:00 a.m., R1 appeared to be sleeping. R1's head was down and eyes were closed. R1 had dark coloring under her eyes. R2 reported if residents seated at the table were sleeping, staff did not typically bother residents and let them sleep where they were.

During interview on 2/14/24 at 12:44 p.m. family member (FM)-A indicated on 2/5/24, they were in the dining room at 11:15 a.m. FM-A remembered R1 sitting at the dining room table and appeared to be sleeping with her head down to her chest. FM-A left dining area and came back in dining area around noon when lunch was being served. R1 had not moved and R1's head was still down. FM-A recalled commotion when R1 received the meal tray and two staff members took R1 to her room. FM-A thought R1 had not moved from the

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position from the time of arrival to the facility to the time staff had removed R1 from the dining area.

During interview on 2/9/24 at 11:05 a.m. R3 recalled being at R1's table on 2/5/24 for both breakfast and lunch meals. R3 reported R1 was not eating breakfast and RN-A was assisting R1, however she was not chewing food at breakfast and did not eat. R1 did not typically require assist to eat. R1 did not "look very good" and appeared to be "out of it". R3 reported R1's head was down at the end of breakfast and appeared to be sleeping. When R3 arrived back at the dining table for lunch R1 was in the same position with head down. At around 12:30 p.m. a nursing assistant said R1 was dead. There was not initially a nurse present, but one joined and R1 was removed from the dining room.

During interview on 2/9/24 at 10:08 a.m., recreational therapist (RT)-A recalled working in the area on 2/5/24. RT-A was in posting activity signs around 9:30 a.m. to around 9:45 a.m. RT-A witnessed R1 sitting alone at the dining table where R1 typically ate meals. R1 was sitting with her head down and not moving. RT-A did not recall staff members around R1 at that time.

During interview on 2/12/24 at 10:23 a.m., NA-B indicated she worked the morning of 2/5/24. NA-B did not provide cares for R1 between breakfast and lunch.

During interview on 2/9/24 at 10:31 a.m., NA-C indicated she worked the morning of 2/5/24. NA-C did not provide cares to R1 between breakfast and lunch.

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F 684	Continued From page 15 During interview on 2/12/24 at 9:48 a.m., registered nurse (RN)-A indicated on 2/5/24 her shift started at 6:00 a.m. RN-A did not receive anything in report regarding R1. RN-A recalled feeding R1 at breakfast and R1 did not typically require help to eat. R1 was more sleepy and fatigued due to Covid. RN-A did not feel a need to assess R1's vitals due to this. R1's last known well time was between 9:00 a.m. and 10:00 a.m. Another resident was talking with R1, however did not hear the conversation. RN-A assisted on another hallway between 10:15 a.m. to 10:30 a.m. Between 10:45 a.m. to 11:35 a.m. RN-A was passing medication to other residents. From 11:35 a.m. to 12:10 p.m. RN-A was on break and recalled at 12:10 p.m. putting her lunch bag behind the nurses desk when staff started to call RN-A's name. RN-A was called to R1's lunch table; R1's lips were blue and she was "getting stiff". RN-A directed NA-A and NA-B to bring R1 back to R1's room, paged NP-A who was in the building, and called emergency medical services (EMS). The NA's brought R1 back to her room. NP-A and EMS arrived, R1 was pronounced dead. During interview on 2/12/24 at 3:29 p.m., nurse manager (NM)-A indicated the expectation is for all residents who have Covid were assessed and monitored twice a day for ten days. The assessments were documented in an infection monitoring note which included temperature, respiratory status/oxygen, lung sounds, isolation precautions, chest X-ray/New Labs, headache/body aches/chills, sore throat/cough/congestion/runny nose/ other symptoms present and current or change of condition. NM-A expected nurses to document resident's symptoms and any change in condition.	F 684		

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On the 11th day post Covid positive test, the nurses were expected to complete a post isolation review assessment and note. This certified the symptoms were improving and residents were safe to come out of their rooms. NM-A reported R1's 11th day of Covid was 2/5/24, and the note had not been completed. NM-A additionally identified R1's chart was missing Covid monitoring notes on both 1/27/24 and 1/31/24 .

During interview on 2/12/24 at 11:54 a.m., nurse practitioner (NP)-A indicated not receiving any communications on 2/5/23 on R1's status until receiving a page at 12:20 p.m. and a return call to RN-A at 12:21 p.m. NP-A did not know how long R1 was down or unresponsive. NP-A entered R1's room and initiated and completed 30 rounds of compressions in bed. NP-A stopped CPR due to clinical signs of death. NP-A indicated it was pretty clear R1 had been expired for a while. R1 had modeling of skin, was cold to touch, head and neck were stiff and head was sticking straight out without any support. NP-A believed R1 was in full rigor. NP-A had anticipated R1 had expired for at least an hour before NP-A had arrived and potentially longer. NP-A reported there was a significant amount of time which was not accounted for. NP-A pronounced time of death at 12:25 p.m..NP-A reported the expectation for any resident with a change of condition to be reported to the provider if there are any concerns including increased weakness or a resident's inability to do tasks they typically would be able to or anything outside of their normal. NP-A was unaware R1's vitals were not assessed on 2/5/24 and indicated it was concerning there was a lack of monitoring for a resident coming off Covid precautions.
During secondary interview on 2/12/24 at 2:14

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p.m. NP-A indicated vital signs are clinical data and without appropriate data it's difficult to make sound judgement on a change of condition. If vitals were appropriately assessed facility staff could have addressed and intervened on a change of condition appropriately. Ultimately it was unknown what led to R1's death.

During interview on 2/12/24 at 12:54 a.m., director of nursing (DON) and administrator, DON reported the internal investigation started on 2/5/24 immediately. R1's last known well time was around 9:00 a.m. to 10:00 a.m. as RN-A reported seeing R1 with another resident. However the reported resident was noted to be near was a bad historian due to dementia and had unreliable/inconstant reporting and unable to interview. DON indicated RN-A should have completed an assessment including vital signs and monitored R1 after NA-A had reported concerns with weakness. DON indicated R1's care plan was not followed. R1 should have been provided care more frequently and it was not appropriate to go from breakfast to lunch without being checked on.

Notification of changes policy dated January 2023, identifies the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.

The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such

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 02/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 notification. Circumstances requiring notification include: 1. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 2. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition. 1. Residents incapable of making decisions: a. The representative would make any decisions that have to be made. b. The resident should still be told what is happening to him or her. 2. Death of a resident: The resident's physician is to be notified immediately in accordance with State law.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 27, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: VNEY11

Dear Administrator:

The above facility was surveyed on February 9, 2024 through February 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: ______ B. WING ______	02/12/2024

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/9/24 through 2/12/24, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H55189604C (MN00100578) with a licensing order issued at 0265, 0565, and 0830. 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. 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 state form. 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 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: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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; 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		3/15/24

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

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of change in condition for 1 of 3 (R1) reviewed for change of condition. Findings include R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R1 had severe cognitive impairment. R1 required set up assist for eating and oral care. R1 required substantial/maximal assist of one person to transfer chair to bed. R1's care plan dated 6/24/22, identified R1 was at a safety risk and may fall due to history of stroke with right sided weakness. R1 had a diagnosis of thrombocytopenia, hypertension, chronic heart failure, and dementia. Staff were to check on R1 regularly to try to anticipate R1's needs. Keep call light and commonly used items within reach. R1's nurse practitioner (NP) note dated 1/26/24, identified R1 was seen by NP due to testing positive for COVID-19 during routine testing on this day. R1 reported to generally not feel well, with symptom onset when awaking in the morning. Symptoms included cough, nasal congestion, body aches, and fatigue. Review of	2 265	Corrected	

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2 265	Continued From page 4	2 265		

symptoms indicates R1's report was limited due to history of dementia. Assessment and plan directed nursing staff to notify provider with any change in patients condition.

R1's vital signs between 1/26/24 and 2/5/24, were reviewed. It was not evident R1's vital signs were obtained on 2/5/24 nor evident of any assessments completed related acute illness.

During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24, her shift started at 7:00 a.m. and R1 wanted to get up around 8:00 a.m. NA-A recalled R1 to be weaker with tasks more than normal, required more assistance to transfer, and was leaning to one side more then the other. R1 required assist to wash her face, brush her teeth, and comb her hair and which was abnormal. NA-A reported R1 was typically more combative with cares, however was not that morning. After she finished R1 cares, NA-A reported to registered nurse (RN)-A R1 was weaker than normal. NA-A indicated RN-A explained to her R1 was just getting over Covid and did not take R1's vital signs. After cares R1 was taken to the dining room for breakfast. NA-A recalled R1 required assist to eat breakfast around 8:00 a.m.- 9:00 a.m. by RN-A which was also abnormal. R1 usually fed herself.

During interview on 2/12/24 at 9:48 a.m., RN-A indicated her shift on 2/5/24, started at 6:00 a.m. and did not receive anything in report regarding R1. RN-A stated NA-A could have reported R1 was weaker than normal, however did not recall. RN-A recalled she assisted R1 with eating breakfast because she was tired and weak, but felt this was due to Covid symptoms. She did not feel there was any need to complete any further

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2 265	Continued From page 5	2 265		

assessments, take vital signs, or notify the physician. RN-A returned from break at 12:10 p.m. and was immediately notified of concerns with R1. When RN-A saw R1 sitting at the table in the dining room, R1's lips were blue and appeared as though she had died. The first-time reporting concerns to nurse practitioner (NP)-A was a page at 12:20 p.m. NP-A called back right away, RN-A stated she told NP-A she was needed right away because R1 had died.

During interview on 2/12/24 at 11:54 a.m., NP-A indicated not receiving any communications on 2/5/23 on R1's status until receiving a page at 12:20 p.m. and a return call to RN-A at 12:21 p.m. NP-A indicated the expectation would be for facility staff to report changes to the provider if there were any concerns. If nursing assistants were to report increased weakness or inability to do things they could typically be able to do NP-A would expect to be notified. During subsequent interview on 2/12/24 at 2:58 p.m. NP-A was not notified of any fatigue, change or abnormal vitals since R1 was diagnosed with Covid and placed on quarantine on 1/26/24. Outside of R1's other co-morbidities R1 was rather stable from NP-A's knowledge. NP-A was not aware there were days R1's vitals and respiratory status was not assessed. NP-A would expect a report on any change of condition.

Policy and procedure titled notification of changes dated April 1st, 2022, identifies the purpose of the policy is to endure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.
Compliance guidelines:
The facility must inform the resident, consult with

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2 265	Continued From page 6 the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Significant change in the resident's physical, mental or psychosocial condition such a deterioration in health, mental or psychosocial status. Death of a resident: The resident's physician is to be notified immediately in accordance with state law. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on notification of change in resident health. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are being treated with appropriate assessments during a change of condition, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		3/8/24

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2 565	Continued From page 7 Based on observation, interview, and document review the facility failed to follow the person-centered care plan for 1 of 1 residents (R1) reviewed for activities of daily living (ADL). Findings included: R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's quarterly Minimum Data Set (MDS) dated 9/15/23, identified R1 had severe cognitive impairment. R1 required set up assist for eating and oral care. Personal hygiene is not completed. R1 required substantial/maximal assist of one person to transfer chair to bed. R1's care plan dated 6/24/22, identified R1 is at a safety risk and may fall due to history of stroke with right sided weakness. The care plan directed staff to check on R1 regularly to try to anticipate R1's needs. Keep call light and commonly used items within reach. R1's bowel and bladder care plan dated 6/26/22 directed staff to offer the bathroom when waking up, after breakfast, before and after lunch, before and after supper, night cares, night, and staff are to remind R1 before activities and as needed per R1's request. R1's care plan dated 12/26/23, identified R1 had ADL deficits and required assistance. The care plan directed staff to assist R1 with repositioning every two to three hours and as needed. During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24. Her shift started at 7:00 a.m. and R1 wanted to get up around 8:00 a.m. NA-A assisted R1 with morning	2 565	Corrected	

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2 565	Continued From page 8	2 565		

cares. NA-A reported R1 went to the dining area following cares and was visualized in dining room around 8:00 a.m.- 9:00 a.m. From 9:00 a.m. to 11:15 a.m. NA-A was assisting other residents for the day and did not provide cares for R1. From 11:15 a.m. to 12:00 p.m. NA-A went on break. At 12:00 p.m. R1 was in the same location as she was last visualized at around 8:00 a.m. to 9:00 a.m. NA-A had not offered or assisted R1 to the bathroom or provide any further assistants.

During interview on 2/12/24 at 9:48 a.m., registered nurse (RN)-A indicated her shift started at 6:00 a.m. and did not receive anything in report regarding R1. RN-A assisted R1 with breakfast and visualized R1 between 9:00 a.m. and 10:00 a.m. as another resident was talking with R1. RN-A assisted on another hallway between 10:15 a.m. to 10:30 a.m. Between 10:45 a.m. to 11:35 a.m. RN-A was passing medication to other residents. From 11:35 a.m. to 12:10 p.m. RN-A was on break . RN-A did not provide cares or interact with R1 during this time.

During interview on 2/12/24 at 4:31 p.m., director of nursing (DON) and Administrator indicated R1's care plan was not followed and R1 went a prolonged period without being checked on. It was inappropriate for R1 to go two to three hours without being checked on and R1 should have been provided incontinence cares and offered to be turned/repositioned per R1's care plan.

Policy and procedure titled comprehensive care plans dated august 2022 indicates it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental

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2 565	Continued From page 9 and psychosocial needs that are identified in the resident's comprehensive assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on implementing comprehensive care plans. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are care plans are being followed, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		3/15/24

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2 830	Continued From page 10 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and monitor after an acute change of condition related to increased weakness/fatigue was identified was identified for 1 of 3 residents (R1) reviewed for change of condition. Findings include R1's face sheet identified R1 had diagnoses which included COVID-19 and chronic diastolic (congestive) heart failure. R1's provider orders for life-sustaining treatment (POLST) dated 6/16/22, identified cardiopulmonary resuscitation (CPR) should be attempted. Medical treatments indicated full treatment. Transfer to hospital and/or intensive care unit if indicated. R1's annual Minimum Data Set (MDS) dated 12/15/23, identified R1 was independent with eating and oral care. R1 required partial to moderate assistance with personal hygiene. R1's cognition was not identified. R1's care plan dated 1/26/24 identified R1 was at risk for exposure of Covid infection due to residing in congregate living facility, co-morbid conditions, advanced age and dependency on	2 830	Corrected	

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caregiver assistance, R1 tested positive for Covid 1/26/24.Staff are to monitor for presence or absence of symptoms: fever, cough, shortness of breath, sore throat, fatigue, muscle/body aches, headache, new loss of taste or smell, congestion or runny noise, nausea or vomiting, diarrhea.

R1's nurse practitioner (NP) note dated 1/26/24 identified R1 was seen by NP due to testing positive for Covid during routine testing on this day. R1 reported to generally not feel well, with symptom onset when awaking in the morning. Symptoms included cough, nasal congestion, body aches, and fatigue. Review of symptoms indicates R1's report was limited due to history of dementia. Assessment and plan directs for nursing staff to notify provider with any change in patients condition.

Progress note dated 1/26/24, indicated R1's temperature was 98.4 with oxygen saturation (02) of 95% on room air. R1 had body aches, runny nose and congestion, and fatigue.

Progress note dated 2/4/24, indicated R1 had poor meal intake per usual and encourage fluids. Temp was 97.5 and 02 saturations were 96% on room air. R1 did not have symptoms of cough/runny nose/congestion and denied fatigue. Lung sounds were clear.

R1's vital signs reviewed between 1/26/24 through 2/4/24 and identified vital signs were not consistently monitored and/or assessed during her Covid illness. The record identified the following:
-Respiratory rate on 1/25/24 was 18 breaths per minute, on 2/1/24 respiratory rate was 16. No other entries were recorded.
-Pulse on 1/25/24 was 67 beats per minute

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(bpm), on 2/1/24 pulse was 64 bmp. No other entries were recorded.
-Blood pressures were recorded once daily between 1/25/24 through 2/4/24 and ranged between 133/60 (on 1/30/24) to 176/57 (1/26/24). Readings were seemingly not outside of R1's baseline.

R1's record did not have any recorded vital signs on 2/5/24, nor evident R1 had been provided toileting and/or repositioning after morning cares were completed. February medication administration record dated 2/5/24 indicated scheduled medication administration was documented as administered at 9:14 a.m.

R1's late entry progress note dated 2/5/24 for 12:20 p.m., included "[R1] who had elected full code status was noted by NARS [nursing assistants] sitting in her w/c [wheelchair] head slumped slightly down at the table. Per staff interview this is how resident often is waiting for her meals as she will nap while waiting for tray. Around 12:20 NAR went to give her the lunch tray and noted her to be unresponsive, blue, and cold to touch. Nurse was notified immediately by NAR. Nurse called NP, who was in building and immediately started chest compressions, the nurse on the floor to assigned to resident called 911. NP states that resident was blue, and Riga [sic] Mortis had started to set. She reported even though it was obvious she was deceased, she decided to complete 1 round of chest compressions." The note indicated R1 had died.

Ambulance record dated 2/5/24, identified paramedics were dispatched at 12:25 p.m. due to a cardiac arrest/death. Assessment included R1 presenting to EMS lying supine (face up) in bed. R1 was pulseless, apneic (involuntarily not

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2 830	Continued From page 13 breathing), and unresponsive. R1 was moved to floor. When moving patient, neck and shoulder were stiff and did not move normally when patient was moved. When R1 was placed on the floor R1's neck and head to not rest on the ground due to rigor. Due to R1's presentation with obvious signs of death, EMS estimates patient had a prolonged downtime. Due to obvious signs of death no further resuscitation efforts were performed. During interview on 2/9/24 at 9:21 a.m., nursing assistant (NA)-A reported to be the primary nursing assistant for R1 on 2/5/24, her shift started at 7:00 a.m. R1 wanted to get up around 8:00 a.m. NA-A recalled R1 was weaker with tasks more then normal, was more difficult to transfer, and was leaning to one side more then the other. R1 required assist to wash her face, brush her teeth, and comb her hair, which was abnormal for R1. NA-A reported R1 was typically more combative with cares, however was not that morning. After she finished R1 cares, NA-A reported to registered nurse (RN)-A R1 was weaker than normal. NA-A indicated RN-A explained to her R1 was just getting over Covid and did not take R1's vital signs. After cares R1 was taken to the dining room for breakfast. NA-A recalled R1 required assist to eat breakfast around 8:00 a.m.- 9:00 a.m. by RN-A which was also abnormal. R1 usually fed herself. From 9:00 a.m. to 11:15 a.m. NA-A was assisting other residents for the day and did not provide cares for R1. From 11:15 a.m. to 12:00 p.m. NA-A went on break. At 12:00 p.m. NA-A returned to the floor and started to pass lunch trays. NA-A recalled R1 being in the same place from breakfast and R1's head was down. NA-A took R1's tray and brought it to R1 and noticed R1 was not responding. NA-A reported R1's hand was cold to touch and	2 830		

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attempted to pick R1's hand up, but it dropped down. NA-A called for RN-A to look at R1. RN-A came over to assess R1 and told NA-A, R1 had passed away. NA-A then removed R1 from the dining room and took her back to her room. The nurse practitioner and emergency medical services were notified.

During interview on 2/9/24 at 10:56 a.m., R2 recalled R1 being at the dining table on 2/5/24 between 8:30 a.m. and 9:00 a.m., R1 appeared to be sleeping. R1's head was down and eyes were closed. R1 had dark coloring under her eyes. R2 reported if residents seated at the table were sleeping, staff did not typically bother residents and let them sleep where they were.

During interview on 2/14/24 at 12:44 p.m. family member (FM)-A indicated on 2/5/24, they were in the dining room at 11:15 a.m. FM-A remembered R1 sitting at the dining room table and appeared to be sleeping with her head down to her chest. FM-A left dining area and came back in dining area around noon when lunch was being served. R1 had not moved and R1's head was still down. FM-A recalled commotion when R1 received the meal tray and two staff members took R1 to her room. FM-A thought R1 had not moved from the position from the time of arrival to the facility to the time staff had removed R1 from the dining area.

During interview on 2/9/24 at 11:05 a.m. R3 recalled being at R1's table on 2/5/24 for both breakfast and lunch meals. R3 reported R1 was not eating breakfast and RN-A was assisting R1, however she was not chewing food at breakfast and did not eat. R1 did not typically require assist to eat. R1 did not "look very good" and appeared to be "out of it". R3 reported R1's head was down

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at the end of breakfast and appeared to be sleeping. When R3 arrived back at the dining table for lunch R1 was in the same position with head down. At around 12:30 p.m. a nursing assistant said R1 was dead. There was not initially a nurse present, but one joined and R1 was removed from the dining room.

During interview on 2/9/24 at 10:08 a.m., recreational therapist (RT)-A recalled working in the area on 2/5/24. RT-A was in posting activity signs around 9:30 a.m. to around 9:45 a.m. RT-A witnessed R1 sitting alone at the dining table where R1 typically ate meals. R1 was sitting with her head down and not moving. RT-A did not recall staff members around R1 at that time.

During interview on 2/12/24 at 10:23 a.m., NA-B indicated she worked the morning of 2/5/24. NA-B did not provide cares for R1 between breakfast and lunch.

During interview on 2/9/24 at 10:31 a.m., NA-C indicated she worked the morning of 2/5/24. NA-C did not provide cares to R1 between breakfast and lunch.

During interview on 2/12/24 at 9:48 a.m., registered nurse (RN)-A indicated on 2/5/24 her shift started at 6:00 a.m. RN-A did not receive anything in report regarding R1. RN-A recalled feeding R1 at breakfast and R1 did not typically require help to eat. R1 was more sleepy and fatigued due to Covid. RN-A did not feel a need to assess R1's vitals due to this. R1's last known well time was between 9:00 a.m. and 10:00 a.m. Another resident was talking with R1, however did not hear the conversation. RN-A assisted on another hallway between 10:15 a.m. to 10:30 a.m. Between 10:45 a.m. to 11:35 a.m. RN-A was

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passing medication to other residents. From 11:35 a.m. to 12:10 p.m. RN-A was on break and recalled at 12:10 p.m. putting her lunch bag behind the nurses desk when staff started to call RN-A's name. RN-A was called to R1's lunch table; R1's lips were blue and she was "getting stiff". RN-A directed NA-A and NA-B to bring R1 back to R1's room, paged NP-A who was in the building, and called emergency medical services (EMS). The NA's brought R1 back to her room. NP-A and EMS arrived, R1 was pronounced dead.

During interview on 2/12/24 at 3:29 p.m., nurse manager (NM)-A indicated the expectation is for all residents who have Covid were assessed and monitored twice a day for ten days. The assessments were documented in an infection monitoring note which included temperature, respiratory status/oxygen, lung sounds, isolation precautions, chest X-ray/New Labs, headache/body aches/chills, sore throat/cough/congestion/runny nose/ other symptoms present and current or change of condition. NM-A expected nurses to document resident's symptoms and any change in condition. On the 11th day post Covid positive test, the nurses were expected to complete a post isolation review assessment and note. This certified the symptoms were improving and residents were safe to come out of their rooms. NM-A reported R1's 11th day of Covid was 2/5/24, and the note had not been completed. NM-A additionally identified R1's chart was missing Covid monitoring notes on both 1/27/24 and 1/31/24 .

During interview on 2/12/24 at 11:54 a.m., nurse practitioner (NP)-A indicated not receiving any communications on 2/5/23 on R1's status until

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receiving a page at 12:20 p.m. and a return call to RN-A at 12:21 p.m. NP-A did not know how long R1 was down or unresponsive. NP-A entered R1's room and initiated and completed 30 rounds of compressions in bed. NP-A stopped CPR due to clinical signs of death. NP-A indicated it was pretty clear R1 had been expired for a while. R1 had modeling of skin, was cold to touch, head and neck were stiff and head was sticking straight out without any support. NP-A believed R1 was in full rigor. NP-A had anticipated R1 had expired for at least an hour before NP-A had arrived and potentially longer. NP-A reported there was a significant amount of time which was not accounted for. NP-A pronounced time of death at 12:25 p.m..NP-A reported the expectation for any resident with a change of condition to be reported to the provider if there are any concerns including increased weakness or a resident's inability to do tasks they typically would be able to or anything outside of their normal. NP-A was unaware R1's vitals were not assessed on 2/5/24 and indicated it was concerning there was a lack of monitoring for a resident coming off Covid precautions. During secondary interview on 2/12/24 at 2:14 p.m. NP-A indicated vital signs are clinical data and without appropriate data it's difficult to make sound judgement on a change of condition. If vitals were appropriately assessed facility staff could have addressed and intervened on a change of condition appropriately. Ultimately it was unknown what led to R1's death.

During interview on 2/12/24 at 12:54 a.m., director of nursing (DON) and administrator, DON reported the internal investigation started on 2/5/24 immediately. R1's last known well time was around 9:00 a.m. to 10:00 a.m. as RN-A reported seeing R1 with another resident. However the reported resident was noted to be

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near was a bad historian due to dementia and had unreliable/inconstant reporting and unable to interview. DON indicated RN-A should have completed an assessment including vital signs and monitored R1 after NA-A had reported concerns with weakness. DON indicated R1's care plan was not followed. R1 should have been provided care more frequently and it was not appropriate to go from breakfast to lunch without being checked on.

Notification of changes policy dated January 2023, identifies the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.

The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification.
Circumstances requiring notification include:
1. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.
This may include:
a. Life-threatening conditions, or
b. Clinical complications.
2. Circumstances that require a need to alter treatment.
This may include:
a. New treatment.
b. Discontinuation of current treatment due to:
i. Adverse consequences.
ii. Acute condition.

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2 830	Continued From page 19 iii. Exacerbation of a chronic condition. 1. Residents incapable of making decisions: a. The representative would make any decisions that have to be made. b. The resident should still be told what is happening to him or her. 2. Death of a resident: The resident's physician is to be notified immediately in accordance with State law. Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		