DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

Administrator
Transitional Care Saint Therese
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

RE: CCN: 245630
Cycle Start Date: February 4, 2022

Dear Administrator:

On March 16, 2022, we notified you a remedy was imposed. On June 24, 2022 the Minnesota Department(s) 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 April 3, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 4, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 15, 2022, 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 May 4, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 3, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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
Licensing and Certification Program

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February 15, 2022

Administrator
Trasitional Care Saint Therese
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

RE: CCN: 245630
Cycle Start Date: February 4, 2022

Dear Administrator:

On February 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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Administrator
Trasitional Care Saint Therese
3300 Oakdale Avenue 4th Floor
Robbinsdale, MN 55422

Re: Event ID: LNYZ11

Dear Administrator:

The above facility survey was completed on February 4, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 4, 2022 (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 August 4, 2022 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245630	A. BUILDING _____ B. WING _____	C 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL CARE SAINT THERESE	**3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422**

(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 2/3/22, until 2/4/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5630011C (MN80289) with a deficiency cited at F610. 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		3/10/22

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

Electronically Signed | 02/25/2022

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 610	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a thorough investigation when a resident left the 4th floor unit making it down to the 1st floor emergency department for 1 of 1 resident (R1) reviewed for elopement. Findings include: R1's medical record was reviewed. R1's face sheet indicated acute respiratory failure with hypoxia, hearing loss, depression, and dependent on supplemental oxygen. R1's Hospital Paperwork dated 1/12/22 until 1/15/22, indicated R1 required assist of 1 with cares and activities of daily living (ADLs) which included transfers and ambulation using cane and transfer belt. R1 required care was recommended for 24 hours a day, 7 days a week due to cognitive and mobility deficits which impacted safety. R1's Hospital Discharge Paperwork dated 1/15/22, indicated R1 admitted to the hospital with acute hypoxemic respiratory failure and sepsis due to bilateral lung bacterial pneumonia, further complicated by systolic heart failure. Acute Hypoxemic respiratory failure present on admission and R1 required 2 Liters (L) of oxygen. R1 discharged with 2 L nasal canal.	F 610	1. Immediate action(s) taken for the identified problem include: Include actions that were performed to address the citation and the date the corrective actions were completed. May require the use of outside resources. As of 1.18.22 Interim Administrator began working with the vendor to ensure that the system was functional. On 1.19.22 Wander Guards and Wrist bands ordered to ensure functionality and ability to utilize them and delayed arrival to facility secondary to delivery concerns nationwide. Staff education initiated on 2.10.22 regarding Saint Therese□s elopement Policy as well as where Wander Guards are kept and how to utilize the electronic system on the unit. Staff have been educated on the behaviors that may present as future elopement risks to prevent like scenario from happening. 2. Identification of similar occurrences of the problem was accomplished by: Include actions that were performed to verify similar occurrences do not occur and the date those actions were completed.	

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F 610	Continued From page 2 R1's Admission Assessment dated 1/15/22, indicated R1 had decreased mobility. R1 had poor safety skills with walker brakes and sit to stand transfers. R1 needed to be reminded to use his walker and was physically mobile. R1's Progress note (PN) dated 1/16/22 at 4:50 a.m., indicated R1 used a walker to ambulate to the bathroom. R1's occupational therapy (OT) PN dated 1/16/22, indicated R1 was surprised he was winded after a walk in the hallway. R1's PN dated 1/17/22, at 2:42 a.m. indicated R1 was missing from room at 2:30 a.m. Staff looked for R1 in every room on the unit and was nowhere to be found. 911 was called to notify of missing person. R1 was found on the first-floor emergency room (ER). R1 stated he was waiting for a bus and was heading home. R1 came back to the unit agitated and stated he will go home. R1 took the stairs to get down to the first floor from the fourth floor. R1 sat at the nurses station with nurses station and wanted to leave the unit. R1's 72 Hour Transitional Care Meeting dated 1/17/22, indicated prior to discharge needed equipment and supplies. R1 used a two-wheel walker with therapy. The Facility Investigation Report undated, included a list of tasks completed related to R1's elopement from the 4th floor; psychiatry evaluation 1/18, family aware, CP updated, Risk management done, tasks updated, email sent to R1's physician, room change closer to the nursing station, cognitive testing, and elopement	F 610	1.18.22 Updated Admissions staff to ensure that any potential Guests that have significant cognition concerns, and or dementia and are ambulatory be screened out to sister Campuses. As of 2.6.22 OT to assist in cognition testing upon their initial evaluation and this will be discussed in morning IDT meetings. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: Include education that was provided, and by whom. Include any policy and procedural changes that were implemented and any effective dates. 2.5 through present DON and PRN Interim Social Services Provide on-going education regarding the facility□s elopement policy, Wander Guard system and behaviors that present as though a Guest may elope. Code Drills regarding a Guest who has eloped from the unit are in progress to prepare staff on all three shifts of their ability to demonstrate hands on the desired actions to take place if a Guest were to elope. This process has been paused secondary to contingency staffing levels. Admissions have been placed on hold since 2.16.22 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Include monitoring efforts such as rounds and systems checks, including frequency	

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F 610	Continued From page 3 assessment complete. Staff (RN-A, NA-A, and NA-B) who worked the night of the elopement were interviewed. The document indicated per staff interview, no staff saw any sign of elopement behavior or saw R1 leave the unit. The interview between NA-A and NA-B lacked details related R1's behavior. RN-A indicated R1 walked unsteady dressed in street clothes. RN-A last saw R1 at midnight and noticed he was gone around 2:00 a.m. RN-A stated he must have taken the stairs since she did not see him go past the nurse's station. R1 was missing for 15 minutes. RN-A thought R1 was a normal TCU patient. The report lacked details to how R1 went from the 4th floor to the 1st floor with or without his assistive mobile devices or oxygen. The facility lacked interview with emergency room (ER) staff or security staff who had found R1. There were no interview with other residents whom resided by R1 at the time of his elopement. R1's admission Minimum Data Set (MDS) dated 1/21/22, indicated R1 wandered 1 to 3 days which put R1 at significant risk to get to a potentially dangerous place. R1 required supervision to walk the corridor; required limited assist for locomotion on unit and dressing. R1 was not steady but able to stabilize without staff asset when he moved from sit to stand position, walked, and surface to surface transfers. R1 used a walker or wheelchair for mobility. R1's care plan dated 2/1/22, indicated impaired cognition as evidenced by wandering. During an observation on 2/3/22, at 10:36 a.m. physical therapist (PT)-A pushed R1's oxygen tank while she walked next to R1 down the hallway. R1 walked slow, dragged his feet while	F 610	and the responsible individuals. Elopement drills to be implemented Monthly beginning in March to serve both staff on-going education as well as ensure the functionality of the secured alarm system. IDT meetings held daily will include the Director of Therapy bringing forward slums/CRP and or BIMs scores. Admission checklist utilized by Clinical Coordinator and/or DON to include elopement assessment completed within 5 days if not sooner. Corrective action completion date: (not to exceed 45th day after the survey).	

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F 610	Continued From page 4	F 610		

he pushed a walker. PT-A asked R1 to pick up his feet and not to shuffle when he walked.

During an interview on 2/3/22, at 11:17 a.m. RN-A stated RN-A stated R1 was confused and unsteady when she saw him try to walk in his room with no mobile device or oxygen around 12:00 a.m. on 1/17/22. RN-A stated R1's oxygen level was low. RN-A stated at sometime after 2:00 a.m. she went to check on R1 and he was gone. RN-A stated she was shocked he was gone as to how unsteady he was when she saw him previously that night. RN-A called 911. RN-A stated 911 received a call that a man who fit R1's description was downstairs and asking for his can or walker. R1 was brought back up to the 4th floor and she had him sit at the nurse's station for the rest of the shift to keep him safe. RN-A stated she just assumed R1 went down the stairs as his room was near the stairwell and she would have seen R1 walk past her if she was at nurse's station to use the elevator. RN-A further stated R1 could have walked past to use the elevator if she was not at the nurse's station helping another resident. RN-A further stated she was the only nurse for the entire floor, so she was not at the nurse's station all night. RN-A further stated it was hard to believe R1 took the stairs from the 4th floor to the 1st floor as he needed an assistive mobile device and oxygen. RN-A further stated she was not sure when R1 left the unit.

During an interview on 2/3/22, at 12:12 p.m. NA-A stated she worked the morning of 1/17/22, when R1 left the building and was found in the first floor emergency room (ER). NA-A stated she last saw R1 around 12:00 p.m. that night and at that time R1 stated he wanted to go home and did not want to be at the facility. NA-A further stated she was

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F 610	Continued From page 5 not aware when R1 left the unit. During an interview on 2/3/22, at 12:30 p.m. NA-B stated around 12:00 a.m. on 1/17/22 she went into R1's room and assisted him back to bed. NA-B stated at that time R1 stated he wanted to go home. NA-B stated since NA-A was aware of R1's request to go home she did not provide additional interventions for R1 prior to his elopement. NA-B was not aware when R1 left the unit. During an interview on 2/3/22, at 3:40 p.m. the interim director of nursing (IDON) stated she had done the investigation related to R1's elopement. IDON stated she was not sure when R1 left the unit. IDON stated she believed R1 when down the stairs as RN-A told her during the investigation that. IDON stated to reference the investigation file for information related to the investigation. A copy of the facility Investigation Policy was requested but not provided.	F 610		