Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 22, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On July 18, 2023, we notified you a remedy was imposed. On November 17, 2023 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 November 13, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 13, 2023 be discontinued as of November 13, 2023. (42 CFR 488.417 (b))

In our letter of July 18, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 13, 2023. 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: Reinspection Results
Event ID: X8KC12, SXEC12, and 4V7Q12

Dear Administrator:

On August 31, 2023, October 4, 2023, and November 17, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on July 10, 2023, July 27, 2023, and October 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 18, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

RE: CCN: 245632
Cycle Start Date: June 13, 2023

Dear Administrator:

On June 23, 2023, we informed you that we may impose enforcement remedies.

On July 10, 2023, the Minnesota Department 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 Region V Office for imposition. The CMS Region V Office 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 September 13, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 13, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 13, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 September 13, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Therese Of Woodbury Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 13, 2023. 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:

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 - 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 December 13, 2023 (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://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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 7/7/23 -7/10/23 , a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were eviewed. H56323458C (MN93849/93877) with no deficiency issued. The following complaints were reviewed. H56323757C (MN94920) with a deficiency issued at F657. 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 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		8/30/23

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

Electronically Signed | 07/24/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 1 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to review, revise, and follow a care plan for 1 of 3 residents reviewed for falls. Findings include: Upon observation on 7/7/23 at 11:32 a.m. Nursing Assistant (NA)-A answered R1's call light to assist R1 to the bathroom. NA-A pushed R1's wheelchair in the bathroom, had R1 place her left hand on the grab by the toilet, while NA-A placed her right arm under R1's right shoulder and used her left hand to pull R1 up with her pants. R1 was unable to fully stand, so NA-A pulled R1 to the standing position with both hands grabbing and pulling on R1's pants. R1 was seated on the toilet. RN-A was brought into the room and told	F 657	1.Immediate action(s) taken for the resident(s) found to have been affected include: On __7/10/23___ the Nurse Manager updated the care plan for Resident # R1. 2.Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. Care plan audit completed 7/20 for LTC residents to ensure accuracy. 3.Actions taken/systems put into place to reduce the risk of future occurrence	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 2 NA-A to put a gait belt on R1. R1's Care plan (CP) dated 3/30/23 indicated on 4/5/23 a revision was made that R1 was to have the extensive assistance of two staff members with the use of a gait belt and two wheeled walker for pivot transfer to the toilet. In addition, on 4/5/23 a revision was made for R1 to have extensive assistance of two staff members for pivot transfers using a gait belt and two wheeled-walker, weight bearing as tolerated (WBAT), anterior hip precautions (no hyperextension, limit external rotated (ER) to 45 degrees. A facility document titled Complete Menu for Day and PM Aid undated indicated under the heading Transfer/Bed mobility indicated the use of two wheeled walker for standing support and pivot. The document did not indicate how many staff required to assist R1 with transfers. Under the title Mobility, the document indicated R1 to be up in wheelchair and to keep the walker and wheelchair away from the side of the bed when she is in bed. The document did not indicate how many staff are required to assist R1 or the anterior hip precautions she had listed on her care plan. Under the heading elimination it indicated R1 was occasionally incontinent of bladder and bowels. R1 wears a small brief and is not on a toileting schedule. Do not wake R1 up at night to change her brief, she will put the call light on then needs to be gotten up and taken to the bathroom. The document does not indicate how many staff are to assist R1 during the night. An email dated 4/21/23 at 1:14 p.m. from physical therapy to all the nursing staff indicated R1 required extensive assistance of one staff	F 657	include: The facility's clinical and Interdisciplinary Team including therapy- Care plan will be monitored weekly and updated to show any changes in status during the IDT meetings. IDT education will be provided on care planning procedure per resident change of status by 7-25-2023. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Nurse managers will review care plans daily for (2) weeks for those residents experiencing a change in status or therapy updates to ensure new or modified interventions have been addressed and documented regarding the resident's care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and every other week for (1) month to assure the review and revision of care plans. Results of audits will be reviewed during monthly QAPI meeting until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 3 member for transfers. R1 was to pivot transfer using a gait belt and two wheeled wheelchair. Step-by-step cues needed. R1 tended to lean back when she first stands, be prepared to stabilize R1. R1's quarterly Minimum Data Set (MDS) dated 5/26/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 13 indicating R1 indicating R1 was cognitively intact. R1 required extensive assistance of one staff member for bed mobility, transferring, dressing, toilet use and personal hygiene. R1's pertinent diagnoses included aftercare following joint replacement surgery, osteoarthritis, fracture of the left humerus and unspecified falls. R1's progress notes dated 3/30/23 - 7/10/23 indicated R1 had six falls at the facility. R1's progress note dated 4/21/23 at 1:06 p.m. R1 fell in her room between her wheelchair and her closet, attempting to reach some papers on her desk. R1 had a two-centimeter (cm) x three cm wide left lateral flat tear area just above the ankle and abrasion mid shin one cm long x two cm. wide. R1's was given a grabber/reacher to prevent further incident, the care plan was updated. R1's progress note dated 5/29/23 at 3:36 p.m. indicated R1 fell in her bedroom. The note did not indicate how the fall happened, it was an unwitnessed fall and R1 was found on the floor shouting for help. R1 was taken to the common area for close supervision. R1 did not obtain any injuries. R1's care plan remained the same with no new interventions.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 4 R1's progress note dated 6/4/23 at 7:30 a.m. indicated at 3:02 a.m. R1 was found on the floor with her body to the floor and both legs on the bed. R1 did not obtain any injures. The following questions on the fall progress note were left blank: 1. When was the resident toileted last? 2. Was the call light on at or around the time of the fall? 3. What was the resident doing at the time of the fall? 4. What action was taken after the fall? 5. What treatments were completed/provided? 5. List the names of the MD/NP who were notified and the time they were notified? 6. List the names of the family who were notified and the time they were notified? Was the care plan updated: What interventions were put in place post fall? Is there anything else that is important to note about this incident/fall? R1's progress note dated 6/5/23 at 11:15 p.m. indicated R1 fell in her bedroom. R1 was found laying on the floor on her back between her bed and her nightstand. R1 was attempted to get herself some water. There were no injures obtained. There were no interventions put into place and the care plan was not updated. R1's progress note dated 6/20/23 at 11:32 a.m. indicated R1 fell, hit her head, and incurred a laceration about 1 inch in length causing bleeding. R1 could not tell staff what she was doing. R1 denied pain, remained alert, was at her base line of mildly confused. R1 was sent to the emergency room. R1's progress note dated 6/20/23 at 6:05 p.m. indicated R1 returned from the hospital with an open wound on her left arm. Antibiotics were ordered.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 5	F 657		

R1's progress note dated 6/22/23 at 1:55 p.m. indicated the facility obtained the after-visit summary from R1's emergency room visit which indicated she had one staple in her head which was to be removed in 10 to 14 days and had a new for Macrobid one capsule for a urinary tract infection.

R1's progress note dated 6/22/23 at 8:54 p.m. indicated R1 complained of left rib post fall. The on-call provider was notified with no new orders provided, except to monitor for shortness of breath.

R1's progress note dated 6/25/23 at 10:30 p.m. indicated R1 fell in her bedroom. She was found lying on her back with both the call light and bed remote in her hands. R1 had bleeding on her head from an old injury. R1's staple in her head was intact. R1 stated she had fallen because she was looking for her call light. There were no new interventions indicated and the care plan was not updated.

R1's progress note dated 6/28/23 at 8:51 p.m. indicated R1 continued to complain of left rib cage pain. An x-ray, a lidocaine patch and Acetaminophen were ordered.

R1's progress note dated 6/29/23 at 1:32 p.m. indicated R1 had a fracture of her left rib cage. R1 was ordered Physical therapy (PT) and Occupational therapy (OT).

R1's progress note dated 7/3/23 at 10:47 a.m. indicated the interdisciplinary team (IDT) met to discuss the fall on 6/25/23 and to add the intervention of leaving the bathroom light on so resident could see the call light was added to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 6 care plan. Upon interview on 7/7/23 at 9:15 a.m. R1 stated she has been at the facility since the end of March. She started out on the floor upstairs, but then it was decided she would live at the facility permanently. R1 stated she sees either PT or OT twice a week, she could not recall which one. R1 was able to describe the last two falls at the facility, however, could not recall the exact dates. She stated on the first fall, she was reaching for an object, got dizzy and she fell against a table in the room. R1 was able to point to the table and pointed to stained blood marks still on the carpet. She stated she was taken to the hospital and the found out she had a urinary tract infection which currently has subsided. R1 stated a few days later she fell again. This fall was at night trying to get up to go to the bathroom. She stated she could not find her call light, so she stood up and fell. R1 stated on one of the falls she suffered a rib fracture. R1 thought it was the first fall because that is when the rib pain began. R1 stated that only one staff member at a time assists her except for the times she has fallen and two staff help her off the floor. R1 stated some staff use a gait belt with her and others don't. R1 was not certain if staff are supposed or if it was the choice of the staff to use the belt or not. R1 stated the only thing she knows that is for certain on her care plan was that staff was not move her surgical leg more than 45 degrees. Upon interview on 7/7/23 at 11:44 a.m. NA-A stated she did not use a gait belt because she smelled bowel movement on R1 and thought it was an emergency and needed to get her on the toilet quickly. NA-A denied knowledge of any hip precautions with R1 and stated she has never	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 7 known R1 to require two staff for transfer assistance. Upon interview on 7/7/23 at 11:58 a.m. Registered Nurse (RN-A) was uncertain how R1 was to transfer. RN-A looked up R1's care and stated R1 was to be transferred with assistance of two staff members and a gait belt. RN-A was not certain if this was an isolated incident or if two staff normally transfer R1. Upon interview on 7/7/23 at 12:20 p.m. licensed practical nurse (LPN)-A unit manager stated, "I did immediate verbal education on the staff member who did not use the gait belt." LPN-A stated that R1 was to be a transferred with two staff members. LPN-A stated she recalled "maybe" staff was transferring her correctly because physical therapy could have downgraded her to assistance of one staff member. LPN-A stated "Well, even if she was downgraded to assistance of one, the staff still was not following the plan." Upon interview on 7/7/23 at 1:45 p.m. Physical Therapist (PT)-A stated R1 is an assistance of one. PT-A states she recalled sending out a nurse communication note to all the nursing staff a while back with R1's assessment. PT-A found the email and provided the emailed assessment to the surveyor. She stated, she sent the email to all the staff to make sure the correct staff member received it. PT-A denied following-up with nursing staff about the changes. Upon interview on 7/7/23 at 1:55 p.m. LPN-A stated she recalls the email where R1 was downgraded 4/21/23. LPN-A stated she intentionally did not change R1's plan of care to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245632	A. BUILDING _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(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 657	Continued From page 8 assistance of one staff with transferring because R1 had fallen that day and she believed it was safe to keep her at assistance of two staff members assisting with the transfers. LPN-A denied have a conversation with therapy about keeping R1 an assistance of two staff for transferring due to the fall. Upon interview on 7/8/23 at 8:40 a.m. NA-B stated he has always transferred R1 with assistance of one and a gait belt. He denied being aware of any hip precautions during transfers. Upon interview on 7/8/23, at 11:00 a.m. Regional Quality Assurance Manager, RN-B stated the plan of care and nursing aid menu should match. She stated that following a fall the staff does check the care plan and are supposed to checking to see if staff are following the care plan. A facility policy titled Fall Prevent Program dated 4/1/2022 indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. And, the facility will review the resident's care plan and update as indicated.	F 657		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 18, 2023

Administrator
St Therese Of Woodbury LLC
7555 Bailey Road
Woodbury, MN 55129

Re: State Nursing Home Licensing Orders
Event ID: X8KC11

Dear Administrator:

The above facility was surveyed on July 7, 2023 through July 10, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, 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

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/7/23 - 7/10/23 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 07/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed with no deficiency issues H56323458 (MN93849/93877). The following complainst were reviewed. H56323757C (MN94920) with a licensing order issued at 0565. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of 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		
2 565	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: Based on observation, interview, and record review the facility failed to review, revise, and follow a care plan for 1 of 3 residents reviewed for falls. Findings include: Upon observation on 7/7/23 at 11:32 a.m. Nursing Assistant (NA)-A answered R1's call light to assist R1 to the bathroom. NA-A pushed R1's wheelchair in the bathroom, had R1 place her left hand on the grab by the toilet, while NA-A placed her right arm under R1's right shoulder and used her left hand to pull R1 up with her pants. R1 was unable to fully stand, so NA-A pulled R1 to the standing position with both hands grabbing and pulling on R1's pants. R1 was seated on the	2 565	1.Immediate action(s) taken for the resident(s) found to have been affected include: On __7/10/23___ the Nurse Manager updated the care plan for Resident # R1. 2.Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. Care plan audit completed 7/20 for LTC residents to ensure accuracy. 3.Actions taken/systems put into place to	8/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 toilet. RN-A was brought into the room and told NA-A to put a gait belt on R1. R1's Care plan (CP) dated 3/30/23 indicated on 4/5/23 a revision was made that R1 was to have the extensive assistance of two staff members with the use of a gait belt and two wheeled walker for pivot transfer to the toilet. In addition, on 4/5/23 a revision was made for R1 to have extensive assistance of two staff members for pivot transfers using a gait belt and two wheeled-walker, weight bearing as tolerated (WBAT), anterior hip precautions (no hyperextension, limit external rotated (ER) to 45 degrees. A facility document titled Complete Menu for Day and PM Aid undated indicated under the heading Transfer/Bed mobility indicated the use of two wheeled walker for standing support and pivot. The document did not indicate how many staff required to assist R1 with transfers. Under the title Mobility, the document indicated R1 to be up in wheelchair and to keep the walker and wheelchair away from the side of the bed when she is in bed. The document did not indicate how many staff are required to assist R1 or the anterior hip precautions she had listed on her care plan. Under the heading elimination it indicated R1 was occasionally incontinent of bladder and bowels. R1 wears a small brief and is not on a toileting schedule. Do not wake R1 up at night to change her brief, she will put the call light on then needs to be gotten up and taken to the bathroom. The document does not indicate how many staff are to assist R1 during the night. An email dated 4/21/23 at 1:14 p.m. from physical therapy to all the nursing staff indicated R1 required extensive assistance of one staff	2 565	reduce the risk of future occurrence include: The facility□s clinical and Interdisciplinary Team including therapy- Care plan will be monitored weekly and updated to show any changes in status during the IDT meetings. IDT education will be provided on care planning procedure per resident change of status by 7-25-2023. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: Nurse managers will review care plans daily for (2) weeks for those residents experiencing a change in status or therapy updates to ensure new or modified interventions have been addressed and documented regarding the resident□s care. The Director of Nursing Services or designee will review a random sample of care plans one (1) time per week for one (1) month and every other week for (1) month to assure the review and revision of care plans. Results of audits will be reviewed during monthly QAPI meeting until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 member for transfers. R1 was to pivot transfer using a gait belt and two wheeled wheelchair. Step-by-step cues needed. R1 tended to lean back when she first stands, be prepared to stabilize R1. R1's quarterly Minimum Data Set (MDS) dated 5/26/23 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 13 indicating R1 indicating R1 was cognitively intact. R1 required extensive assistance of one staff member for bed mobility, transferring, dressing, toilet use and personal hygiene. R1's pertinent diagnoses included aftercare following joint replacement surgery, osteoarthritis, fracture of the left humerus and unspecified falls. R1's progress notes dated 3/30/23 - 7/10/23 indicated R1 had six falls at the facility. R1's progress note dated 4/21/23 at 1:06 p.m. R1 fell in her room between her wheelchair and her closet, attempting to reach some papers on her desk. R1 had a two-centimeter (cm) x three cm wide left lateral flat tear area just above the ankle and abrasion mid shin one cm long x two cm. wide. R1's was given a grabber/reacher to prevent further incident, the care plan was updated. R1's progress note dated 5/29/23 at 3:36 p.m. indicated R1 fell in her bedroom. The note did not indicate how the fall happened, it was an unwitnessed fall and R1 was found on the floor shouting for help. R1 was taken to the common area for close supervision. R1 did not obtain any injuries. R1's care plan remained the same with no new interventions. R1's progress note dated 6/4/23 at 7:30 a.m.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 indicated at 3:02 a.m. R1 was found on the floor with her body to the floor and both legs on the bed. R1 did not obtain any injures. The following questions on the fall progress note were left blank: 1. When was the resident toileted last? 2. Was the call light on at or around the time of the fall? 3. What was the resident doing at the time of the fall? 4. What action was taken after the fall? 5. What treatments were completed/provided? 5. List the names of the MD/NP who were notified and the time they were notified? 6. List the names of the family who were notified and the time they were notified? Was the care plan updated: What interventions were put in place post fall? Is there anything else that is important to note about this incident/fall? R1's progress note dated 6/5/23 at 11:15 p.m. indicated R1 fell in her bedroom. R1 was found laying on the floor on her back between her bed and her nightstand. R1 was attempted to get herself some water. There were no injures obtained. There were no interventions put into place and the care plan was not updated. R1's progress note dated 6/20/23 at 11:32 a.m. indicated R1 fell, hit her head, and incurred a laceration about 1 inch in length causing bleeding. R1 could not tell staff what she was doing. R1 denied pain, remained alert, was at her base line of mildly confused. R1 was sent to the emergency room. R1's progress note dated 6/20/23 at 6:05 p.m. indicated R1 returned from the hospital with an open wound on her left arm. Antibiotics were ordered. R1's progress note dated 6/22/23 at 1:55 p.m. indicated the facility obtained the after-visit	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 summary from R1's emergency room visit which indicated she had one staple in her head which was to be removed in 10 to 14 days and had a new for Macrobid one capsule for a urinary tract infection. R1's progress note dated 6/22/23 at 8:54 p.m. indicated R1 complained of left rib post fall. The on-call provider was notified with no new orders provided, except to monitor for shortness of breath. R1's progress note dated 6/25/23 at 10:30 p.m. indicated R1 fell in her bedroom. She was found lying on her back with both the call light and bed remote in her hands. R1 had bleeding on her head from an old injury. R1's staple in her head was intact. R1 stated she had fallen because she was looking for her call light. There were no new interventions indicated and the care plan was not updated. R1's progress note dated 6/28/23 at 8:51 p.m. indicated R1 continued to complain of left rib cage pain. An x-ray, a lidocaine patch and Acetaminophen were ordered. R1's progress note dated 6/29/23 at 1:32 p.m. indicated R1 had a fracture of her left rib cage. R1 was ordered Physical therapy (PT) and Occupational therapy (OT). R1's progress note dated 7/3/23 at 10:47 a.m. indicated the interdisciplinary team (IDT) met to discuss the fall on 6/25/23 and to add the intervention of leaving the bathroom light on so resident could see the call light was added to the care plan. Upon interview on 7/7/23 at 9:15 a.m. R1 stated	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 7 she has been at the facility since the end of March. She started out on the floor upstairs, but then it was decided she would live at the facility permanently. R1 stated she sees either PT or OT twice a week, she could not recall which one. R1 was able to describe the last two falls at the facility, however, could not recall the exact dates. She stated on the first fall, she was reaching for an object, got dizzy and she fell against a table in the room. R1 was able to point to the table and pointed to stained blood marks still on the carpet. She stated she was taken to the hospital and the found out she had a urinary tract infection which currently has subsided. R1 stated a few days later she fell again. This fall was at night trying to get up to go to the bathroom. She stated she could not find her call light, so she stood up and fell. R1 stated on one of the falls she suffered a rib fracture. R1 thought it was the first fall because that is when the rib pain began. R1 stated that only one staff member at a time assists her except for the times she has fallen and two staff help her off the floor. R1 stated some staff use a gait belt with her and others don't. R1 was not certain if staff are supposed or if it was the choice of the staff to use the belt or not. R1 stated the only thing she knows that is for certain on her care plan was that staff was not move her surgical leg more than 45 degrees. Upon interview on 7/7/23 at 11:44 a.m. NA-A stated she did not use a gait belt because she smelled bowel movement on R1 and thought it was an emergency and needed to get her on the toilet quickly. NA-A denied knowledge of any hip precautions with R1 and stated she has never known R1 to require two staff for transfer assistance. Upon interview on 7/7/23 at 11:58 a.m.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 Registered Nurse (RN-A) was uncertain how R1 was to transfer. RN-A looked up R1's care and stated R1 was to be transferred with assistance of two staff members and a gait belt. RN-A was not certain if this was an isolated incident or if two staff normally transfer R1. Upon interview on 7/7/23 at 12:20 p.m. licensed practical nurse (LPN)-A unit manager stated, "I did immediate verbal education on the staff member who did not use the gait belt." LPN-A stated that R1 was to be a transferred with two staff members. LPN-A stated she recalled "maybe" staff was transferring her correctly because physical therapy could have downgraded her to assistance of one staff member. LPN-A stated "Well, even if she was downgraded to assistance of one, the staff still was not following the plan." Upon interview on 7/7/23 at 1:45 p.m. Physical Therapist (PT)-A stated R1 is an assistance of one. PT-A states she recalled sending out a nurse communication note to all the nursing staff a while back with R1's assessment. PT-A found the email and provided the emailed assessment to the surveyor. She stated, she sent the email to all the staff to make sure the correct staff member received it. PT-A denied following-up with nursing staff about the changes. Upon interview on 7/7/23 at 1:55 p.m. LPN-A stated she recalls the email where R1 was downgraded 4/21/23. LPN-A stated she intentionally did not change R1's plan of care to assistance of one staff with transferring because R1 had fallen that day and she believed it was safe to keep her at assistance of two staff members assisting with the transfers. LPN-A denied have a conversation with therapy about	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31025	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE OF WOODBURY LLC	7555 BAILEY ROAD WOODBURY, MN 55129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 9 keeping R1 an assistance of two staff for transferring due to the fall. Upon interview on 7/8/23 at 8:40 a.m. NA-B stated he has always transferred R1 with assistance of one and a gait belt. He denied being aware of any hip precautions during transfers. Upon interview on 7/8/23, at 11:00 a.m. Regional Quality Assurance Manager, RN-B stated the plan of care and nursing aid menu should match. She stated that following a fall the staff does check the care plan and are supposed to checking to see if staff are following the care plan. A facility policy titled Fall Prevent Program dated 4/1/2022 indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. And, the facility will review the resident's care plan and update as indicated. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		