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 Therefore, the NATCEP prohibition is rescinded.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

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2022

CMS Certification Number (CCN): 245630

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 3, 2022 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
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June 29, 2022

Administrator
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3300 Oakdale Avenue 4th Floor
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RE: CCN: 245630
Cycle Start Date: February 4, 2022

Dear Administrator:

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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,

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Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
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Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

March 16, 2022

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

RE: CCN: 245630
Cycle Start Date: March 3, 2021

Dear Administrator:

On February 15, 2022, we informed you that we may impose enforcement remedies.

On March 3, 2022, the Minnesota Department(s) of Health and Public Safety 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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 May 4, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 4, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 4, 2022.

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 $11,292, 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 May 4, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Transitional Care Saint Therese will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 4, 2022. 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:

Pete Cole, RN Unit Supervisor
Metro Team C District 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
Office/Mobile: (651) 249-1724

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 August 4, 2022 (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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have 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

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 _____	03/03/2022

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
E 000	Initial Comments On 3/1-3/3/22 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/1/22-3/3/22, a standard recertification 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 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 substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		3/21/22

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

Electronically Signed | 03/23/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 1 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R11) who was dependent on staff for meeting activities of daily living (ADLs) had trimmed toenails. Findings Include: R11's admission Minimum Data Set (MDS) dated 1/4/21, indicated R11 was cognitively intact and was dependent on staff to provide bathing, dressing lower body, and taking on and off footwear. R11's admission record indicated R11 had diagnoses which included diabetes, atrial fibrillation, chronic kidney disease, muscle weakness, and long-term use of anticoagulation. R11's care plan dated 12/29/21, identified R11 had an activity of daily living (ADL) self-care deficit and potential impairment to skin integrity. R11's care plan directed staff to lotion dry intact skin only and monitor for abnormalities. R11's care plan further indicated R11 was diabetic, and it was okay for nursing assistant to clip R11's nails on bath day. R11's nursing task form dated 3/3/22, indicated R11 could receive non-diabetic nail care as needed. During observation on 3/1/22, at 3:34 p.m. R11 toenails on both feet were long, rough and dark yellow colored. The left foot second toe was bent at the middle joint toward the large first toe and	F 677	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F677 SS=D ADL Care Provided for Dependent Residents: Saint Therese TCU ensures and provides ADL care to dependent residents. This includes completion of the Minimum Data Sheet to determine assistance needed to care for resident, evaluating resident independence with ADLs and creating a care plan to ensure needs are met. Fingers and Toenail policy was reviewed and remains accurate. R11's nails were trimmed by a licensed nurse during the survey. Remaining residents care plans were reviewed for nail care needs and were up to date. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on resident nail care. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be	

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F 677	Continued From page 2 the toenail was leaving a red nail shaped mark in the toe. All toenails were greater than one centimeter long passed the end of toes on both feet and were thick and dark yellow in color. During observation on 3/2/22, at 10:45 a.m. R11 was observed being wheeled to the shower room in a hospital gown with legs partially covered by a sheet. R11's feet were visible and R11's toe nails were long and thick, and both feet had purple skin discoloration. When interviewed on 3/1/22, at 3:35 p.m. R11 stated aides are not able to assist with her nail care because she is diabetic and on blood thinners. R11 further stated she asked one week ago for the nurse to have a podiatrist come in and look at her nails and she still had not heard any follow-up on the request. R11 stated she was worried about the long toenails cutting into her skin and causing her another infection. R11 denied refusing nail care or showers. When interviewed on 3/1/22, at 11:45 a.m. registered nurse (RN)-A stated she had not assessed R11 nails since she moved to this hallway last week. RN-A stated R11 is diabetic and nail care could only be provided by a nurse and R11 could be at risk for infection due to the length of her nails. RN-A further stated R11 did report to her she had only bed baths since being admitted to the facility with no nail care provided. RN-A described R11 toenails as thick, long, yellow, and not having been cut in months. RN-A stated nail care should be provided on bath day or during skin assessments. When interviewed on 3/3/22, at 9:52 a.m. director of nursing (DON) stated non diabetic nail	F 677	responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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F 677	Continued From page 3 care is meant for residents who were not diabetic and nail care could be provided by a certified nursing assistant (CNA). R11 is diabetic and on blood thinners and aides should not cut her nails. Stating this practice could leave the resident at risk for bleeding or infection if not cut correctly. DON further stated R11 was a diabetic, on blood thinners and the CNA should not cut R11's toenails because it could put R11 at risk for infection or bleeding. R11 had no indications in her chart she was provided nail care or referred to podiatry. The facility's Finger and Toenails Care policy revised on 2/18, indicated to clean the nail bed, keep nails trimmed, and to prevent infection. The policy directed staff to provide regular trimmings.	F 677		
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 observation, interview and record review the facility failed to ensure proper positioning was implemented for 1 of 1 residents (R11) observed to have concerns with foot drop positioning. Findings include:	F 684	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to	3/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 4 R11's significant change minimum data set (MDS) dated 2/4/22, indicated R11 was cognitively intact and demonstrated no behaviors. R11 required extensive assistance of two staff for physical assist with bed mobility, dressing, and toilet use. R11's care area assessment (CAA) dated 2/4/22, indicated R11 triggered and was care planned for activity of daily living (ADL) and falls. R11's face sheet dated 3/3/22, indicated R11 had diagnoses of diabetes, chronic kidney disease, muscle weakness, and history of falling. R11's care plan dated 3/2/22, indicated R11 had decreased mobility related to weakness and required staff to use a Hoyer lift with assist of two staff, for turning and sitting up in bed . R11 care plan further indicated she was unable to ambulate. R11's care plan lacked interventions related to R11's foot drop. R11's physician progress notes (PN) dated 3/1/22, indicated R1 had right foot drop with a cool right foot and poor capillary refill (a physical exam technique that provides clinicians with a simple way of determining the adequacy of blood circulation) Review of R11's progress notes (PN) lacked indication R11 was assessed or had interventions for foot drop. On 3/1/22, at 2:48 p.m. R11's right foot was observed to have a significant foot drop with no support pillow, or brace. R11's right foot was in a downward position, away from the body with her	F 684	dispute these findings in their entirety at any time and in any legal action. F684 SS=D Quality of Care Saint Therese TCU ensures and provides quality care to dependent residents. This includes completion of the Minimum Data Sheet to determine assistance needed to care for resident, evaluating resident care needs, completing skin assessment, and creating a care plan to ensure needs are met. Patient Care Pathway policy was reviewed and remains accurate. R11's care plan was updated to include PROM of lower extremities and propping right foot with pillows to reduce risk of foot drop. Remaining residents were assessed for risk of foot drop with none detected. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on resident assessment and s/s of foot drop. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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F 684	Continued From page 5	F 684		

toes pointing directly out and straight. R11's foot was cool to touch, pale and purple red in color compared to the left foot.

On 3/2/22, at 10:15 a.m. R11 was observed sitting in a shower chair and her right front part of foot was pointing straight down to the floor with toes dragging on the ground.

On 3/1/22, 3:04 p.m. R11 stated she had a foot drop in her right foot and she was concerned because she is diabetic and was worried it would get worse. R11 stated she has not been seen by therapy or assessed by therapy for this issue and staff were not propping up her foot. R11 stated she had advised the aides and nurses before regarding her concerns related to the foot not being propped up. R11 stated, "I do not want to loose my foot."

On 3/2/22, at 11:54 a.m. During interview registered nurse (RN)-A stated she was unaware R11 had issues with foot drop because she just transferred down from the other hallway. RN-A stated R11 did have a significant foot drop on her right foot upon her observation. RN-A stated the nursing assistant should be propping the foot with a pillow to prevent worsening of her foot drop. RN-A further stated the aides currently do not have interventions on the care plan related to R11 foot drop. RN-A stated R11 could experience worsening of the foot drop or long term effects such as a contracture by not having interventions in place. During observation R11 did not have pillows or propping of the foot. R11 had significant non-pitting edema (swelling caused due to excess fluid accumulation in the body tissues) from toes to mid thigh. R11's toes were observed to be a deep reddish purple color and

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	245630	A. BUILDING _____ B. WING _____	03/03/2022

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F 684	Continued From page 6 were cool to the touch. RN-A stated R11 just returned from a shower. During interview on 3/2/22, at 11:55 p.m. R11 stated she had not refused cares, and staff have not offered to position her foot or offer therapy address the foot drop. During interview on 3/3/22, at 8:40 a.m. physical therapist (PT)-A stated R11 had no evaluation, treatment recommendations, or care plan interventions while residing in the facility. PT-A further stated R11 had a history of foot drop prior to admitting to the facility and would recommend providing range of motion, complete frequent skin checks, and propping the foot up to help prevent contractures in the future. She stated because R11 was mainly in bed R11 would be more at risk for complications to foot drop if not propped up appropriately. During interview on 3/2/22, at 1:30 p.m. director of nursing (DON) stated R11 did not have an assessment, orders, or treatment provided for foot drop. DON stated R11 had a history of foot drop and R11 had no recommendations or interventions from therapy to direct staff to prop R11 foot up. DON stated her expectation nursing was staff should have assessed R11 and asked provider for recommendations. The facility policy titled Patient Care Pathway dated 3/11, indicated therapist would review residents diagnosis and co-morbidities when resident is admitted to the facility. The policy directed staff to implement interventions for positioning and modify the plan of care.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		3/22/22

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F 695	Continued From page 7 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to a ensure physician order was obtained for oxygen therapy use for 2 of 2 residents (R1, R11), reviewed for respiratory care. Findings include: R1's Face Sheet printed 3/3/22, indicated R1's diagnoses included: acute and chronic respiratory failure, chronic diastolic heart failure, and dependence on oxygen. R1's quarterly Minimum Data Set (MDS) dated 12/9/21, indicated R1 was cognitively intact and required one-person physical assists for all activities of daily living (ADL's). R1's care plan printed on 3/3/22, indicated oxygen therapy as ordered for heart failure. R1's Order Summary Report dated 3/3/22, indicated the following orders: 3/2/22, continue oxygen 2 liters per minute (lpm), keep oxygen saturations greater than or equal to 88 percent, every shift. Prior to 3/2/22, R1's	F 695	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F695 SS= D Respiratory/Tracheostomy Care and Suctioning Saint Therese TCU ensures and provides proper respiratory interventions to all residents. This is completed by completion of the Minimum Data Sheet to determine assistance needed to care for resident, evaluating resident care needs, observation of resident's respiratory status, and creating a care plan to ensure needs are met. Oxygen Administration policy was reviewed and remains accurate. R11's and R1's MD orders and care plan were reviewed and updated to reflect continuous oxygen. Remaining residents	

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F 695	Continued From page 8 physician orders had no indications R1 was on continous oxygen. R1's progress note (PN) dated 3/2/22, at 11:56 p.m. indicated R1 had a new order for continuous oxygen at two liters per minutes by nasal canula. R1's physician PN dated 3/1/22, lacked oxygen in the order summary. During observation on 3/1/22, at 2:45 p.m. R1 was observed sitting on his bed, with nasal canula in nose, hooked up to wall regulator turned on to 2 lpm. A portable oxygen cylinder was sitting next to his window. R11's Face Sheet printed 3/3/22, indicated R11 diagnoses included: pneumonia due to coronavirus disease 2019, acute respiratory failure with hypoxia (person is not exchanging oxygen properly in their lungs) and dependence on supplemental oxygen. R1's admission MDS dated 1/4/22, indicated R11 was cognitively intact and required extensive assistance of two people for ADL's. R11's MDS further lacked documentation R11 required oxygen while in the facility. R11's care plan printed dated 3/3/22, lacked evidence R11 was on oxygen therapy. R11's Order Summary Report lacked orders for continous oxygen. R11's PN dated 2/26/22, indicated R11 was on 2 lpm of oxygen throughout the shift. During observation on 3/1/22, at 3:34 p.m. R11	F 695	care plan and MD orders were reviewed and were accurate for oxygen use. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on resident care plan and proper documentation of MD orders. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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F 695	Continued From page 9 was observed lying in bed with head of bed elevated with nasal canula on attached to wall regulator at 2 lpm. During interview on 3/2/22, at 7:26 a.m. registered nurse (RN)-B confirmed she did not see an order for continous oxygen to be used in R1's or R11's orders. RN- B further stated R1 and R11 should of had an order placed for continous oxygen. During interview with director of nursing (DON) on 3/2/22, at 1:15 p.m DON stated R1 or R11 did not have an order for continuous oxygen and nursing staff would not know the lpm dosage to use for R1 or R11. DON stated she thought because of a change in staffing and from when R11 went to the hospital and came back orders were discontinued and not reinitiated. DON stated her expectation for nursing staff are to enter oxygen orders as received by the physician. DON stated she was not aware R1 did not have oxygen on his orders. The facility Oxygen Administration policy, revision date 10/18, indicated the purpose was to provide guidelines for safe oxygen administration. The policy directed staff to verify there was a physician's order for oxygen and to review the resident's care plan.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		3/22/22

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F 812	Continued From page 10 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the freezer and refrigerator in the long-term care (LTC) kitchenette had daily documentation of appropriate temperatures. The facility further failed to properly label food which was brought in by resident's families. This had the potential to affect 5 of 5 residents (R1, R4, R8, R11, R15), residing on this unit. Findings include: Facility Fridge Temp log dated 2/22, indicated no temperature was documented for days 1 through 16, 18, 20, 22, and 27 of the month for the refrigerator. The documenated temperatures for the refrigerator showed temperatures from 34 degress to 40 degrees. No documenation of freezer temperatures were taken for the month. Daily Temperature log dated 3/22, indicated no temperatures were taken for 3/1/22 or 3/2/22. The refrigerator temp on 3/3/22, indicated the	F 812	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F812 SS=F Food Procurement, Store, Prepare, Serve-Sanitary Saint Therese TCU ensures and provides food that is stored, prepared and served in a sanitary manner. This is completed by monitoring food storage and refrigerator temperatures daily. All outside food brought in by families should be documented with name of resident, date it was brought in and discard date. Food Brought by Family policy was reviewed and remains accurate. All refrigerator and freezers in the facility	

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F 812	Continued From page 11 temperature was 41 degrees. The freezer temperatures were 9 degrees on 3/1/22 at 12:55 p.m. and 2 degrees on 3/2/22. During observation on 2/28/22, at 1:21 p.m. the refrigerator did not have a thermometer inside and the temperature logs on the refrigerator had no record of temperatures being logged. Temperature within refrigerator's felt cool. During observation on 3/1/22, at 1:45 p.m. the LTC Kitchenette Nourishment room was observed without thermometer in the refrigerator portion of the combined refridgerator/freezer unit. Inside the refidgerator was cartons of milk, boost, juice, butter cheese sticks, and four bags with unlabeled food containers. A undated bag had a number 404 on a container inside containing pot roast with no date or discard date indicated. In addition there was undated and unlabeled bag containing a black plastic convenience store salad with brown colored lettuce and liquid dripping into the bottom of bag. Additionaly, there was a bag containing a round plastic container with white fish and pale colored french fries inside without a date or discard date. The freezer portion's temperature displayed on the thermometer was at 9 degrees fahrenheit within the freezer was containers of lemon ice and ice cream which were soft when touch. Temperature log indicated freezer temperatures need to be zero or below. During observation on 3/3/22, at 11:43 a.m. the temperature of the refrigerator for LTC Kitchenette Nourishment room was found to be at 41 degrees fahrenheit, with no thermometer found in the freezer.	F 812	were provided a thermostat. Staff was re-educated on daily monitoring and documentation of refrigerator and freezer temperature. All staff was re-educated on proper labeling of food brought in by family's policy. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on proper monitoring of refrigerator and freezer temps and proper documentation of food brought in by families. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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F 812	Continued From page 12 On 3/1/22, at 1:30 p.m. the health unit coordinator (HUC) verified the four bags with food in them were for residents brought in by family. HUC further stated the containers were not labeled or dated with a discard date. She further stated all staff should be labeling the food when it is brought in and when it is found and undated or unlabeled it needs to discarded. On 3/1/22, at 2:12 p.m. patient care assistant (PCA) stated there was no thermometer in the refrigerator, and she was unable to check the temperature. PCA further stated the refrigerator felt warm. PCA further stated the food in bags were not labeled or dated with discard date. PCA stated staff should be labeling the food when it is brought in and when it is found undated or unlabeled it needs to discarded. She stated the night shift should be checking the temps on the freezer and refrigerator and if any concerns were noted to report them to maintenace to follow up on. On 3/1/22, at 7:30 p.m. PCA stated when food is brought into the facility by family it needs to be labeled by staff with a resident identifier, date it was brought in and date to discard. PCA stated the salad was turning brown and was dripping in the bag. The pot roast was not dated, labeled and did not have a discard date. A small plastic storage dish contained a piece of cooked white fish and French fries without a label indentifying the date or resident. On 3/2/22, at 1:45 p.m. when interviewed, director of nursing (DON) stated the expectation was for night staff to complete the temperature logs before they leave in the morning. DON stated, anytime a staff member goes in the	F 812		

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F 812	Continued From page 13 refrigerator they should look at the food that is brought in by family and ensure it is labeled correctly with date and discard date. DON stated if the food is not labeled it needs to be discarded . DON stated, if the food appears to be spoiling it needs to be discarded and residents and family receive a policy for food brought in by visitors. On 3/2/22, at 8:30 a.m. when interviewed administrator stated we do not have additional temperature logs. Administrator further stated her expectations were the temperatures would be done daily to ensure appropriate temperatures for both the refrigerator and freezer. The facility policy titled Foods Brought by Family and Vistitors, dated 10/17, indicated food brought in by family or visitors would be labeled and stored. The policy indicated the residents name and use by date will be placed on containers and nursing staff would discard food or perishable foods on or before the use by date.	F 812		
F 881 SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ongoing implementation an	F 881	This plan and response to these survey findings is written solely to maintain	3/22/22

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F 881	Continued From page 14 antibiotic stewardship and infection surveillance program which included to monitor appropriateness of antibiotic use to prevent antibiotic resistance. This had the potential to affect all 5 residents in the facility. Findings include: The untitled infection surveillance (IS) documents dated 2/22, provided by the facility used to track infections and antibiotic use included unit, resident name, room number, admit date, existing infection, infection type, body system, surveillance definition, onset date, device type, insertion date, date of removal, device days, infection risk factors, diagnostic performed, test date, specimen source, results, antibiotic resistant organism, antibiotic, class, dose, infection type, risk factors, antibiotic reassessment time out performed. The IS lacked evidence that antibiotic use and infection surveillance were appropriately reviewed, and appropriate action taken after the date of 2/10/22. During interview on 3/2/22, at 1:30 p.m. director of nursing (DON) stated, antibiotic stewardship was a problem and identified antibiotic stewardship as an area which seemed to be missed since staff are quitting. DON further stated it was more than two weeks ago since a staff person was working in the infection preventionist role. When interviewed on 3/3/22, at 12:08 p.m. registered nurse (RN)- D stated she currently had no further documentation past 2/3/22, for antibiotic stewardship was monitored. RN-D stated her expectation is for the health unit coordinator, charge nurse, or floor nurse to enter	F 881	certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F881 SS=C Antibiotic Stewardship Saint Therese TCU has developed an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The role of the Infection Preventionist was reviewed and revised to include expectations and staff coverage in absence of an IP. During the last few days of the TCU being open, the DON took responsibility to ensure antibiotic usage was reviewed and in compliance with prescribing guidelines and clinical practice guidelines relevant to antibiotic stewardship. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on antibiotic use and stewardship. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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F 881	Continued From page 15 that in an order so it will trigger residents who required to be monitored for use of antibiotics or who may be diagnosed with an infection monitoring. RN-D stated the reason the monitoring was missed is because she had been busy filling in and working multiple locations. RN-D stated she believed a resident returned from the hospital recently and was on an antibiotic. When interviewed on 3/3/22, at 12:40 p.m. administrator stated the problem the facility had is we have not had someone consistently in the role of infection prevention position since the last full-time person was here six months ago. Administror stated, currently the infection preventionist from another facility site is trying to take on this role for this site as well. The facility policy Antibiotic Stewardship, revised 7/16, indicated the antibiotic usage and outcome data would be collected and documented using a facility approved antibiotic surveillance tracking form. The data would be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. The infection preventionist would review all antibiotics within 48 hours to determine if continued therapy is justified. The facility should ensure clinical criteria were met prior to ordering diagnostic testing and appropriate communication with staff and providers. Further the facility should assess antibiotic use on a regular basis and monitor compliance with prescribing expectations and clinical practice guidelines relevant to antibiotic stewardship.	F 881		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		3/22/22

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F 887	Continued From page 16 §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum,	F 887		

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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 887	Continued From page 17 the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccinations were offered and received for 1 of 1 resident (R15) reviewed for COVID-19 vaccination status. Findings include: R15's admission Minimum Data Set (MDS) dated 2/14/22, indicated R15 was admitted to the facility on 2/14/22. R15's Order Summary dated 3/3/22, lacked documentation a COVID-19 vaccine was ordered for R15.	F 887	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement not an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F887 SS=D Immunization Saint Therese TCU ensures and provides proper vaccinations to all residents. This includes review of resident's vaccination history and documentation of vaccination	

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	245630	A. BUILDING _____ B. WING _____	03/03/2022

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TRANSITIONAL CARE SAINT THERESE	3300 OAKDALE AVENUE 4TH FLOOR ROBBINSDALE, MN 55422

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F 887	Continued From page 18 R15's progness notes (PN) lacked documentation R15 was fully vaccinated for COVID-19. Further, R15's EMR lacked documentation R15 was offered the COVID-19 vaccine upon and/or after admission. R15's EMR lacked documentation of COVID-19 vaccine contraindications. When interviewed on 3/2/22, at 12:24 p.m. R15 stated he had received one vaccination of COVID-19 in December 2021 and would like to get his second one. R15 stated he was not offered since his admission to the facility, to receive his second COVID-19 vaccination. When interviewed on 3/2/22, at 2:20 p.m. registered nurse (RN)-D stated the facility could be set up monthly COVID-19 vaccination clinic or the facility's pharmacy could administer the vaccination but require a minimum of 10 vaccinations for the pharmacy to come onsite. RN-D further stated R15 should have been offered to be taken to another facility campus for the vaccination but stated it would have required non emergent transportation to transport R15. RN-D stated upon discharge from the facility the COVID-19 vaccination would be recommended to be given. When interviewed on 3/2/22, at 1:03 p.m. director of nursing (DON) stated R15 was missing his second COVID-19 vaccination, and the vaccination had not been offered while residing in the facility. DON further stated R15 had not been given the vaccination because R15 required a non-emergent transportation ride to a clinic because of his non-weight bearing status. A facility COVID-19 vaccination policy was requested and not received.	F 887	status. COVID-19 vaccination policy was reviewed and remains accurate. Resident R15's discharge paperwork identified he would like a COVID-19 second vaccination at new facility. Remaining residents were assessed for vaccination status with none detected as non-compliant. At this time the facility is temporarily closed, and no staff or residents remain. Upon reopening of the facility, all staff would be trained during the onboarding process on vaccination status documentation and ensuring residents requiring/requesting a vaccination are offered one in a timely manner. Audits would then be completed weekly for 4 weeks and reviewed at the monthly QAPI meeting for direction or change, as well as timeline for completion based on compliance. The administrator and/or designee will be responsible for maintaining compliance with this requirement. Plan was completed as much as possible prior to closure.	

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	245630	A. BUILDING **01 - MAIN** B. WING _____	**03/02/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/03/2022. At the time of this survey, Transitional Care Saint Therese was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/23/2022

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Transitional Care Saint Therese is located on the 4th floor of a 9-story hospital that was built in 1972 and was determined to be of Type I(332) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and patient sleeping rooms that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 32 beds and had a census of 7 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.3.2.1. This deficient finding could have a widespread impact	K 353	TCU by Saint Therese at North Memorial Hospital 4th floor. The TCU by Saint Therese is temporarily closed due to lack of staffing. If reopened, all of the plan of correction will resume immediately. Sprinkler System and Maintenance testing	4/3/22

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K 353	Continued From page 3 on the residents within the facility. Findings include: On 03/02/2022 at 12:15 PM, observation revealed that the last 5-year inspection and gauge replacement or recalibrating was completed on 11/15/2016. An interview with the Supervisor of Maintenance and Engineering verified this deficient finding at the time of discovery.	K 353	on automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25 standard for the Inspection. 1. A schedule will be developed to inspect the above systems and what staff will monitor 2. The schedule of inspections due monthly on the sprinkler and standpipe system is monitored And reviewed at the monthly Quality Improvement Committee meeting. The administrator will request from the North Memorial Maintenance Director to document each month's inspection to ensure the inspection took place and outcome documented. 3. The director of maintenance service at North Memorial is responsible to ensure inspection. The Administrator is responsible to ensure the Director of Maintenance inspects and sends a form to report findings monthly for the QI meeting. 4. See above in answer #3 5. The proposed date for completion will be April 3, 2022.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355		3/18/22

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K 355	Continued From page 4 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.1 and 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/02/2022 at 10:00 AM, it was revealed by observation the fire extinguisher by the West Stairs #5 was blocked by a wheelchair scale. An interview with the Interim Administrator verified this deficient finding at the time of discovery.	K 355	TCU by Saint Therese at North Memorial Hospital 4th floor. The TCU by Saint Therese is temporarily closed due to lack of staffing. If reopened, all of the plan of correction will resume immediately. All fire extinguishers must be always accessible for use if needed. 1. Administrator will add this Ktag to the Quality Improvement agenda on a monthly basis and document extinguishers are free from obstruction for use. The monitoring of extinguishers accessibility will be reported at the Quality Improvement Committee monthly. The weight scales have already been moved as of 3/18/2022. 2. If during inspection of accessible extinguisher's, the administrator or designee will reeducate staff on why this is against the fire safety codes. 3. The administrator or designee will monitor monthly for any obstruction to fire extinguishers. 4. See answer to #3. 5. It was corrected on 3/18/22.	
K 712 SS=F	Fire Drills	K 712		3/22/22

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K 712	Continued From page 5 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/02/2022 at 12:00 PM, it was revealed by a review of available documentation the following fire drills were not performed during these times: 1) The First Quarter of 2022 2) The Second Quarter of 2021 3) Second and Third shift of the Third Quarter of 2021 4) Second and third Shift of Fourth Quarter of 2021 An interview with the Interim Administrator verified this deficient finding at the time of discovery.	K 712	TCU by Saint Therese at North Memorial Hospital 4th floor. The TCU by Saint Therese is temporarily closed due to lack of staffing. If reopened, all of the plan of correction will resume immediately. Fire Drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. 1. The administrator or designee will fill out the “Keys Fire Drill Report” during the fire drill and have all staff sign that they received information about staff’s performance during fire drill. If any issues with staff performance during fire drill, they will be reeducated on proper procedure.	

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K 712	Continued From page 6	K 712	2. The administrator or designee will execute the monitoring of any fire alarm. The findings will be reported to the Quality Improvement committee monthly. Any infraction to the policy will be reeducated for all staff involved at that specific fire drill. 3. The administrator or designee will report findings at each quality improvement meeting. 4. The administrator or designee is responsible to ensure each fire drill/actual was according to Fire Safety codes. 5. Will follow plan if the TCU is opened with residents on the floors.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923		3/18/22

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K 923	Continued From page 7 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the storage of the oxygen tanks per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.2.3(11) and 11.6.5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 03/02/2022 at 09:00 AM, it was revealed by observation that an "E" Cylinder was unsecured in the oxygen storage room. 2) On 03/02/2022 at 09:00 AM, it was revealed by observation the "E" Cylinders stored in the	K 923	TCU by Saint Therese at North Memorial Hospital 4th floor. The TCU by Saint Therese is temporarily closed due to lack of staffing. If reopened, all of the plan of correction will resume immediately. Gas Equipment – Cylinder and Containers Storage. The gas equipment must be separated by 20 feet If there is combustibles are in the same area. Empty cylinders must be separated from full tanks. There also must be a sign on the door at minimum: “CAUSTION OXIDIZING GAS (ES) STORED WITHIN NO SMOKING.”	

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K 923	Continued From page 8 oxygen storage room were not separated, empty from full. An interview with the Interim Administrator verified this deficient finding at the time of discovery.	K 923	1. All Gas tanks have been removed from the 4th floor as of 3/18/22. If this unit re-opens, the Director of Nursing or designee will ensure it is store away from combustibles at least 20 feet. The Director of Nursing or designee will monitor the usage and storage to meet all fire safety codes. 2. Director of Nursing or designee will monitor the storage on a monthly basis and report any adverse findings, correct the findings and reeducate staff to the correct usage and correct storage of tanks. 3. The Director of nursing or designee will report on any adverse findings to the QI committee and show the corrective action taken. 4. The Director of Nursing or designee. 5. KTag was corrected on 3/18/22. A new storage area will be chosen if this unit is reopened.	