CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY	ID: U9RL Facility ID: 00261
1. MEDICARE/MEDICAID PROVIDER N (L1) 245518 2.STATE VENDOR OR MEDICAID NO. (L2) 712242000		3. NAME AND AD (L3) ST THERES (L4) 8000 BASS I (L5) NEW HOPE	DDRESS OF FACII SE HOME LAKE ROAD		(L6) 55428	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 6. DATE OF SURVEY 7. 01/29/1 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b):		Complian	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP IS CERTIFIED AS nnce With Requirements ce Based On:	09 ESRD 10 NF 11 ICF/IID 12 RHC		6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	258 (L18) 258 (L17)	B. Not in Cor	Acceptable POC mpliance with Prog and/or Applied Wa		4. 7-Day RN (Rural SN) 5. Life Safety Code * Code: A*	F) 8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 258 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	ICF (L42) E SHOW LTC CANCI	IID (L43) ELLATION DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Kathleen Lucas, Uni	t Supervis	Date :	01/31/2019		18. STATE SURVEY AGENCY Alison Helm, Enfor	
PA	RT II - TO BE	E COMPLETED	BY HCFA RI	(L19) EGIONAI	OFFICE OR SINGLE ST	(L20
DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Par 2. Facility is not Eligible	icipate (L21)		MPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE OF PARTICIPATION 02/01/1988 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions:	4. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 01 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement
28. TERMINATION DATE:	29	. INTERMEDIARY/0	(L45) CARRIER NO.		30. REMARKS	
	(L28)	03001		(1.31)		

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

01/11/2019

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 31, 2019

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

RE: Project Number S5518030, H5518082, H5518084, and H5518085

Dear Administrator:

On January 29, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 25, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2019

CMS Certification Number (CCN): 245518

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

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 January 15, 2019 the above facility is recommended for:

258 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 258 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,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: U9RL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I	- TO BE COMP	PLETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00261
MEDICARE/MEDICAID PROVIDER (L1) 245518 2.STATE VENDOR OR MEDICAID NO. (L2) 712242000	NO.	3. NAME AND AI (L3) ST THERES (L4) 8000 BASS I (L5) NEW HOPE	SE HOME LAKE ROAD	LITY	(L6) 55428	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SU	JPPLIER CATEGO	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	258 (L18) 258 (L17)	Complian1. X B. Not in Co		ram	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: B*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 258 (L37) (L38)	/N 19 SNF (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK	RKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
17. SURVEYOR SIGNATURE Lisa Ciesinski, HFE NE II		Date: 01/0	07/2019	(L19)	18. STATE SURVEY AGENCY A	
P	ART II - TO BE	COMPLETED	BY HCFA RE		OFFICE OR SINGLE ST.	,
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pace 2. Facility is not Eligible			MPLIANCE WITH GHTS ACT:	CIVIL	1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 02/01/1988	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	**
25. LTC EXTENSION DATE: (L27)	A. Suspensior B. Rescind Sus	of Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
20 TERMINATION DATE	20	DITEDMENTARY	(L45)		20 DEMADIC	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CAKKIEK NU.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 26, 2018

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

RE: Project Numbers S5518030, H5518082, H5518084, and H5518085

Dear Administrator:

On December 6, 2018, a standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 6, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5518082, H5518084, and H5518085.

This survey found the most serious deficiencies in your facility 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. In addition, at the time of the December 6, 2018 standard survey, the Minnesota Department of Health, completed an investigation of complaint numbers H5518082, H5518084, and H5518085 that were found to be substantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 15, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the
 deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

St Therese Home December 26, 2018 Page 2

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

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

St Therese Home December 26, 2018 Page 3

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 6, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 6, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900 St Therese Home December 26, 2018 Page 4

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

PRINTED: 01/09/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		245518	B. WING			12/	06/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OT THEE	DESE LIOME			80	00 BASS LAKE ROAD		
SIINER	RESE HOME			NE	EW HOPE, MN 55428		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted on 12/3/ recertification surve	iance with CMS Appendix Z edness Requirements, was 18 through 12/6/18, during a ey. The facility is in compliance Z Emergency Preparedness	FΟ	00			
	through 12/6/18 and	rvey was conducted 12/3/18 d complaint investigations ed at the time of the standard					
		emplaints H5518082, 518085 were found to be 84.					
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 550 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Resident Rights/Ex		F 5	50			1/15/19
LABORATOR	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and DER/SUPPLIER REPRESENTATIVE'S SIGN	ΙΔΤΙΙΡΕ		TITLE		(X6) DATE

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.

Electronically Signed

01/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245518	B. WING_		C 12/06/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428	, 12.00.2010		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION		
F 550	this section. §483.10(a)(1) A fact with respect and diversident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights §483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercis The resident has thrights as a resident or resident of the U §483.10(b)(1) The resident can exerci interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the farights and to be supexercise of his or h subpart. This REQUIREMED	including those specified in including those specified in all the specified in an environment that ance or enhancement of his or ecognizing each resident's cility must protect and of the resident. facility must provide equal are regardless of diagnosis, and, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all so of payment source. e of Rights. the right to exercise his or her of the facility and as a citizen	F 55	1) Resident R705 is no longer an	active		
		ailed to ensure residents were		resident at the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		L' IDENTIFICATION NUMBER: L' '		K2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245518	B. WING			12/0) 6/2018	
	PROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD EW HOPE, MN 55428	121	7072010	
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 550	provided care in a from personal odor R141) who used caurinary incontinence. Findings include: R705's admission recently admitted trincluded overactive of prostate, Parking depressive disorder On 12/6/18 at 8:29 sitting in wheelchauncovered urinary hooked to it hanging chair. R705's door open, as staff and a personal aide (Prime. The urinary dontain approxima R705 verbalized the hanging on the recindicated, facility string in which are indicated, facility string on the recindicated, facility string in urinary drainage bag. On 12/6/18 observed between 8:40 a.m. observed sitting in urinary drainage bathanging on the left R705's door was ostaff (NA-D, NA-E, passed by. The urinobserved to contain	dignified manner, and free r for 2 of 5 residents (R705 and atheters and were reviewed for	F 5	550	2) Staff will provide care in a dignifice manner. 3) Staff will be re-educated on the importance of covering up a urinary drainage bag so that it is not observe others and providing Foley catheter hygiene care to prevent odor. 4) Weekly audits will be completed to observation of cares and/or resident interviews to ensure residents with ucatheters are free from odor and baccovered. 5) DON and/or designee is responsimonitoring compliance. 6) The QAPI committee will provide direction or change when necessary will dictate the continuation or compof this monitoring process based on compliance noted.	ed by by curinary gs are ble for and letion		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245518	B. WING		12	2/06/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 BASS LAKE ROAD NEW HOPE, MN 55428	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 550	recliner chair but di clean the drainage left side of the recli indicated, she remi and cleaning the drempty or clean the 9:16 a.m., R705 ex bag with urine hang. On 12/6/18 observation between 9:16 a.m. observed sitting in uncovered urinary chooked to it hangin recliner chair with ulanguage pathologiand the drainage brecliner chair. At 10 room to answer cal assistant with the unassisted R705 but with 200 milliliter of confirmed the uncocondom hooked to was hanging on the removed it, emptied bag. At 11:20 a.m., therapist (OT) assistant did not do the cook of the importance of confirming interview on indicated, the expebag should be cover in the chair or wheelshould have been esto maintain resident	d not remove, empty and bag that was hanging on the ner chair. At 9:15 a.m., PA nded NA-D about emptying ainage bag but NA-D did not drainage bag with urine. At pressed dislike of drainage ging on the recliner chair. ations were conducted and 10:35 a.m., R705 was still recliner chair with an drainage bag with condom g on the left side of the urine. At 9:36 a.m., the speech st (SLP) went to resident room ag was still hanging on the 1:21 a.m., RN-I went to R705's I light and R705 needed rinal to urinate and RN-I did not empty the drainage bag urine. At 10:35 a.m., RN-I wered drainage bag urine. At 10:35 a.m., RN-I wered drainage bag with it with 200 milliliters of urine e right end of the recliner. RN-I d, clean and stored drainage RN-I stated, occupational sted R705 with morning cares catheter care as OT suppose she spoke with OT regarding	F 5	50				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				OMPLETED C	
		245518	B. WING				06/2018	
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 BASS LAKE ROAD NEW HOPE, MN 55428	, 12/	00/2010	
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 550	(MDS) dated 11/16, significant cognitive extensive assistant including dressing, mobility. The MDS diagnoses to including diabetes, obstructive right hip dislocation. R141's care plan realized that had an indwer urinary retention armay increase his ristract infections. R14 incontinent of bower was used. The care with catheter cares and update the the practitioner (NP) as On 12/06/18, at 8:3 his room, in bed with catheter with catheter cares.	2/18 indicated R141 had a impairment and required be with activities of daily living grooming, bathing, and identified R141's medical le: anemia, heart failure, we uropathy, urinary retention, arthritis, and pain. Revised on 12/3/18, indicated elling Foley catheter related and obstructive uropathy which sk for recurrence for urinary 41 was also identified as all and an incontinence brief e plan directed staff to to assist every shift and as needed. Sted staff to manage catheter medical doctor (MD) or nurse a needed.		550				
	45 degree angle. A pronounced upon e R141's urinary cath	s elevated to approximately a smell of urine was entering the resident room. Leter bed bag was observeding on the bed frame.						
	his room resting un R141's eyes were of was observed to at connected to the be	25 a.m. R141 was observed in der the covers on his bed. closed. Urinary catheter tubing tach to bed bag which was ed and was covered. A more y odor was noted at this time.						
	(RN)-L stated she	51 a.m. registered nurse could smell a urinary odor.						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245518	B. WING				C 06/2018	
	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD IEW HOPE, MN 55428	127	00/2010	
(X4) I D PREF I X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 550	coming from the blacatheter bag. RN-L bypassing of the catheter) which was change the catheter provision of care for should not be an orange the catheter provision of care for should not be an orange the catheter bypassing was noted the nurse as the catheter bypassing was noted the catheter bypassing wet was cause skin breakdon oticeable to others in the room with the catheter bypassing wet was cause skin breakdon oticeable to others in the room with the catheter bypassing wet was cause skin breakdon oticeable to others in the room with the catheter bypassing wet was cause skin breakdon oticeable to others in the room with the catheter bypassing of the cathete	dor. RN-E thought it may be ack cloth bag covering the stated there could be atheter (Leaking around the sindicative of the need to be ack. RN-L proceeded with a r R141. RN-L stated there are dor as it was a closed system. The edor could indicate a sign of a vidration. RN-L stated when the edot in the edo	F	550				

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F 550		ge 6 o Foley catheter use and how was requested, but not	F 5	50		
	provided. Self-Determination CFR(s): 483.10(f)(1	,	F 5	61		1/15/19
	promote and facilitathrough support of	e right to and the facility must ate resident self-determination resident choice, including but phts specified in paragraphs (f)				
	activities, schedules waking times), heal care services consi	esident has a right to choose s (including sleeping and lth care and providers of health stent with his or her interests, plan of care and other his of this part.				
	choices about aspe	esident has a right to make ects of his or her life in the ificant to the resident.				
	with members of th	esident has a right to interact e community and participate in s both inside and outside the				
	participate in other religious, and comminterfere with the rig facility. This REQUIREMENT by: Based on interview	esident has a right to activities, including social, nunity activities that do not ghts of other residents in the NT is not met as evidenced and document review, the		1) Resident R64 interviewed to o		
	facility failed to acco	ommodate bathing		bathing preferences. Care plan	eviewed	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	` ´COM	E SURVEY PLETED
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F 561	preferences for 1 or for choices. Findings include: R64's diagnosis includes disease, and depreduced Data Set (MDS) da cognition was intacted on 12/3/18, at 3:53 able to choose how only get one shower that R64 had not as was not offered any R64's care plan data received one shower supervision. During an interview nursing assistant (Nave to request and they can receive and stated the bath or some Nursing Assistant Cresident has two bath of the state of t	luded ulcerative colitis, liver ssion. A quarterly Minimum ted 10/3/18, indicated R64's t. p.m. when asked if R64 was often he bathed, R64 stated I r on Wednesday. R64 stated sked for more showers and more. ed 9/25/18, indicated R64 er a week and needed on 12/5/18, at 9:20 a.m. with JA)-B stated the residents other bath or shower. NA-B howers are listed on the care Guide. NA-B stated no ths or showers on hall two. on 12/5/18, at 9:33 a.m. with ident asks for another bath or the nurse and they would stated residents would have to nor shower they are not	F 56	and updated. 2) Staff will offer residents the opto make choices regarding their lapreferences. 3) Nursing staff will be re-educative residents rights to make choices regards to their cares and activition 4) Residents will be offered the otheir bathing preferences. 5) Bathing preferences will be diswith residents or others involved residents' care upon admission a quarterly care conferences. 6) Weekly audits will be complete interviewing residents or others in residents' care (family/friends, the resident is unable to speak for themselves. This will ensure resare being offered and accommodatheir bathing preference. 7) DON and/or designee is responsitoring compliance. 8) The QAPI committee will providirection or change when necess will dictate the continuation or coof this monitoring process based compliance noted.	ed on in es. hoice for cussed in nd at the ed by etc.), if ridents lated nsible for de ary and mpletion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	During an interview RN-F stated resider bath or shower a wread RN-F stated we not would like more bath A policy was reques showers none was Baseline Care Plan CFR(s): 483.21(a)(on 12/5/18, at 1:27 p.m. with hits could have more than one eek they have to request it. ask regularly if the residents his or showers. Sted for scheduling baths or provided. 1)-(3) Insive Person-Centered Care	F 5				1/15/19
	§483.21(a)(1) The fimplement a baselin that includes the inseffective and person that meet professio. The baseline care p(i) Be developed with admission. (ii) Include the minimal necessary to prope including, but not lire (A) Initial goals base (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recoms §483.21(a)(2) The fromprehensive care plan if the comsolidations.	facility must develop and the care plan for each resident structions needed to provide in-centered care of the resident nal standards of quality care. It is a plan must-thin 48 hours of a resident's formum healthcare information of the resident in the to-ed on admission orders.					

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F 655	admission. (ii) Meets the requir (b) of this section (ethis section). §483.21(a)(3) The resident and their resident and their resident and their resident are limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the face (iv) Any updated info of the comprehensing This REQUIREMENT by: Based on interview the facility failed to was developed with failed to provide a value that the resident and/or residents (R43) recompleted facility failed to was developed with failed to provide a value that the resident and/or residents (R43) recompleted facility failed to was developed with failed to provide a value of the resident and/or residents (R43) recompleted facility failed to was developed with failed to provide a value of the resident and/or residents (R43) recompleted facility failed to was developed with failed to provide a value of the resident and/or residents (R43) recompleted failed to was developed with failed to provide a value of the resident and demendent failed to the resident failed to was developed with failed to provide a value of the resident failed to was developed with failed to provide a value of the resident failed to provide a value o	rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary plan that includes but is not of the resident. The resident medications and the facility and personnel acting	F6	355	1) Resident R43 baseline care plan completed upon admission. Reside POA offered and provided with a writ care plan summary. 2) A 48 hour baseline care plan will be completed with all residents upon admission and a written care plan summary will be provided to the resi and/or representative. 3) Nursing staff will be re-educated completion of the 48 hour baseline of plan and ensuring residents and/or representatives are offered and provided to the resident and written care plan summary. 4) Weekly audits will be completed on ewly admitted residents to ensure residents have completed baseline and/or representative have been offewritten care plan summary.	nt and tten be dent on the care vided on all 48 t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
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F 655	heart failure. R43's physician ord R43 required multip not limited to: Cour milligrams (mg) ever Wednesday, Thursh Monday, Friday, last a day, Metoprolol (Cosartan (HTN medication) 75mg a medication to decreated for demential), along dietary orders, drest of other health care R34's medical recourage with the residence R34 or rewritten care plan supprovided for R43. On 12/6/18, at 2:32 (DON) stated she rewritten care plan or his representative and none was found 11/19/18 the facility residents or their rewritten information with the residents or their rewritten information or or thei	lers dated 10/24/18, indicates ole medications including but madin (a blood thinner), 4 ery Sunday, Tuesday, day, Saturday and 4mg on six (diuretic medication) 20mg CHF medication) 25mg a day, dication) 25mg a day, al vascular accident a day and Haldol (antipsychotic ease excitement in the brain g with laboratory orders, sing changes and monitoring eneeds. In a lacked evidence of an initial or direct staff how to care for all dis. R43's record also lacked presentative had been given a summary of cares being p.m. the director of nurses eviewed R43's chart for initial or documentation to show R43 ereceived written information d. DON stated that on realized some of their lave 48 hour care plans and expresentatives did not receive	F 65	5) All current residents were revensure 48 hour baseline care place completed and that the resident/representative was provide written care plan summary. 6) DON and/or designee is responsitoring compliance. 7) The QAPI committee will providirection or change when necess will dictate the continuation or coof this monitoring process based compliance noted.	ns were ided with nsible for de ary and mpletion	
	requested and none ADL Care Provided CFR(s): 483.24(a)(3	for Dependent Residents	F 67	7		1/15/19

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F 677	§483.24(a)(2) A resout activities of daily services to maintair personal and oral harmonic personal grooming R141) reviewed for and who were depended and wh	ident who is unable to carry y living receives the necessary in good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview, and document illed to provide routine for 2 of 4 residents (R151, activities of daily living (ADL's) endent on staff for their care. Cluded diabetes, chronic didementia. Inimum Data Set (MDS) dated R151 was cognitively MDS indicated R151 needed be from staff with personal ented 11/19/18, indicated R151 sistance from one staff for ene needs. Son on 12/4/18, at 9:37 a.m. inately 15 white chin hairs 1/4 in R151 stated it bothered	F 677	1) Both residents R141 and R151 w provided personal grooming. R141 longer an active resident. 2) Staff will offer and provide routine personal grooming to all residents w are dependent upon staff for their ca 3) Nursing staff will be re-educated each resident who is unable to carry activities of daily living will receive th necessary services to maintain groom and all personal cares. 4) Weekly audits will be completed the ensure residents are being provided routine grooming and personal hygical formulation or compliance. 6) The QAPI committee will provide direction or change when necessary will dictate the continuation or compliance noted.	is no who are. what out e ming o ene. ble for	
	During an observati	on on 12/5/18. at 7:46 a.m.				

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F 677	nursing assistant (Nassisting R151 with R151 to the sink in brushing R151's techair, took the hair of the garbage and the and threw it in the gonot removed and Noroom. During an interview NA-C stated we show want to be shaved, stated we would us women. During an interview stated female resid have chin hairs. Noth had the chin hairs of the shave the residents LPN-A stated R151 R151. When interviewed of director of nursing (residents want chin should be doing the we should have offen hairs cleaned up. A facility policy was provided regarding R141's significant of the significant of the significant of the state of the significant o	MA)-A and NA-C where morning cares. NA-A brought the room and assisted with eth. NA-A combed R151's ut of the comb and threw it in en took the disposable razor garbage. R151 chin hairs were A-A took R151 to the dining on 12/5/18, at 8:33 a.m. ould shave the residents who even the women. NA-C e a disposable razor for the on 12/6/18, at 8:23 a.m. NA-A ents should be shaved if they A-A confirmed R151 had not emoved prior to breakfast. on 12/6/18, at 9:28 a.m. urse (LPN)-A stated with expectation of staff was to a who were in need of shaving, does allow the staff to shave on 12/6/18, at 1:32 p.m. the DON) stated if female hairs cleaned up then we at for them. The DON stated ered R151 to have the chin requested, however none was	F 6	77			

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F 677	significant cognitive extensive assistant including dressing, mobility. The MDS diagnoses to includ diabetes, obstructive right hip dislocation. R141's care plan real R141 had an indwe urinary retention are may increase his ritract infections. R14 incontinent of bower was used. R141's owas at risk for deverto bowel incontinent to right hip dislocation understanding/commence repositioning needs ulcers and had a blow. The care plan has his blue Preval. On 12/06/18, at 8:3 his room, in bed with head of the bed wad 45 degree angle. A pronounced upon er R141's urinary cath covered and hanging foam boots were in Con 12/06/18, at 11: his room resting un R141's eyes were own observed to at connected to the best of the pronounced to the best observed to at connected to the best of the pronounced to the best observed to the best observed to the best of the pronounced to the best observed to the best of the pronounced to the best observed to the best of the pronounced to the best observed to the best observed to the best of the pronounced to the best observed to the best observed to the pronounced to the pro	e impairment and required be with activities of daily living grooming, bathing, and identified R141's medical le: anemia, heart failure, we uropathy, urinary retention, a, arthritis, and pain. Evised on 12/3/18, indicated elling Foley catheter related and obstructive uropathy which sk for recurrence for urinary 41 was also identified as ell and an incontinence brief care plan also indicated R141 eloping a pressure ulcer related ince, decreased mobility related inn, lack of apliance with turning and so, and history of pressure ood blister on his left great directed staff to ensure R141 on boots on while in bed.	F 67	77			

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F 677	R141's foam boots On 12/06/18, at 11 (RN)-L stated she RN-E joined surve noted the urinary of be bypassing of th catheter) which wa change the cathete provision of care for should not be an of RN-L also stated to of an infection or of bypassing was not the nurse as the co properly. RN-L state of the catheter byp being wet was und skin breakdown, a noticeable to other in the room with the foam boots should resident is in bed of breakdown. On 12/06/18 at 12 (NA)-H stated she personal hygiene to odor of urine impre hygiene but was si had informed RN- bypassing of the of foam boots were r she did not wish to wished to wear his she had performed pericare for inconti-	:51 a.m. registered nurse could smell a urinary odor. Fyor and RN-L in the room and odor. RN-L stated there could e catheter (Leaking around the as indicative of the need to er. RN-L proceeded with or R141. RN-L stated there odor as it was a closed system. The odor could indicate the signs dehydration. RN-L stated when ted this should be reported to atheter was not functioning ted she had not been informed comfortable and could cause is well as the odor being res, adding no one wants to stay the smells. RN-L stated R141's if the in place on both feet when due to the potential for skin could cause in the potential for skin that provided R141 with this morning. NA-H stated the coved with provision of personal till noticeable. NA-H stated the atheter. NA-H had stated the not in place this morning and owaken R141 to inquire if he at foam boots, although stated depersonal hygiene and	F6	577			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION NG	COM	COMPLETED		
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F 677	(FM)-B stated R147 catheter for over six urinary tract infection observed urinary seconds observed the urine stated she had not today but stated R1 whole thing." FM-A the presence of a parall urine in the rope smell urine in the rope stated she had night and had failed stated the foam body pressure concerns.	I has had his indwelling a months and has experienced ons. FM-B stated she has ediment in the tubing and has to be dark in color. FM-B observed a personal odor 41 would be "offended by the stated "I would be upset by ersonal odor if others could from." Indicate the reaches a contract of the reaches and the reaches a contract of the reaches and the reaches a contract of the reaches and the reaches and the reaches a contract of the reaches and the reaches a contract of the reaches and the reaches and the reaches and the reaches a contract of the reaches and the reaches and the reaches a contract of the reaches and the reaches a contract of the reaches and the reaches and the reaches a contract of the reaches a contract of the reaches and the reaches a contract of	F 6			1/15/19	
SS=D	applies to all treatm facility residents. Be assessment of a re that residents recei accordance with pro- practice, the compri- care plan, and the right This REQUIREMEN by: Based on observative review the facility far position was maintal adaptive wheelchailand failed to investi	fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered		Resident R116's wheelchair s was lengthened, wheelchair armi elevated, OT orders received for wheelchair positioning. Resident bruising of unknown cause was r to MDH and investigation initiated.	R703 eported		

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F 684	related skin concer Findings include: R116's quarterly Mi 10/29/18, indicated impairment and rec with transfers and r diagnoses included chronic pain, a histo fracture with routine R116's care plan da had decreased mol balance, impaired of (Alzheimer's type), a history of falls, an care plan directed s recline (HBTR) cha On 12/04/18, at 10: seated in the day ro with a head and ne R116 was observed back of the chair ar of the chair. The he providing support to was present at an a was observed leani chair during music positioned to the ri knees pointing to th on the footrest. At t below the head sup R116's outer aspec observed extending	nimum Data Set (MDS) dated R116 had severe cognitive eived extensive assistance nobility. R116's medical: Alzheimer's, dementia, ory of falling, and a closed healing. ated 5/24/18, indicated R116 polity related to an impaired cognition, dementia impaired vision, chronic pain, d a right femur fracture. The staff to use a high back tilt	F	684	completed. 2) Staff will provide quality care to a residents, which includes ensuring residents are able to maintain an uposition while in his or her wheelch to report any bruises of unknown of supervisor and administrator/designations. Staff will be re-educated that ear resident must receive cares to ensure the or she is positioned correctly which in the wheelchair and protocol to forwhen bruise of unknown origin is not also with the wheelchair will be completed observation of residents to ensure they are positioned correctly and all maintain an upright position when in wheelchair/chair. Nurse managers review all nurse documentation for units to ensure that any bruises of unknown origin were reported to supervisor and administrator/designation of the QAPI committee will provided direction or change when necessar will dictate the continuation or composition of this monitoring process based or compliance noted.	that pright air and rigin to nee. ch ure that nen up llow oted. by that ole to n a will their nee. sible for e y and oletion	

On 12/04/18, at 3:46 p.m. R116 was observed

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F 684	seated in her whee upright position with hand side of the ch head/neck cushion support to the resid herself towards the cues, however, her by the head/neck s On 12/05/18, at 10: seated in her whee was sitting with her and upper body obside of the chair outhead/neck cushion observed seated in positioned back antwisted to the right. On 12/05/18, at 11: assistant (TMA)-Assining up with head/R116's leaning to the pressure for the side of the chair outhead/R116's leaning to the pressure for the side on 12/05/18, at 11: (RN)-E stated the volengthened. RN-E is support as this was upper body. RN-E at the left side, and plarm rest. On 12/06/18, at 11: the day room seated hips center and positions, with her upper body. With her upper body, with her upper body.	Ichair. R116 is seated in an her head leaning to the left air back. Although the is in place,it provides no ent. R116 was able to shift center of the chair with verbal head remained unsupported upport. 09 a.m. R116 was observed Ichair in the dayroom. R116 eyes closed, with her head served leaning towards the left tside the support of the . At 10:54 a.m. R116 was her wheelchair with hips d to the left, and her knees with her feet on the footrest. 02 a.m. trained medical stated R116's head was not neck support. TMA-A stated he side would increase	F 68	34		

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		245518	B. WING	B. WING		1	06/2018
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F 684	referral process to the positioning but was R703's admission readmitted to this facilidiagnoses including side, diabetes type. In addition, the electindicated R703's we 12/3/18 but did not on the right side of R703's care plan urpotential for an activated assistance maximal function refracture. In addition dated 12/4/18, directure. In	requested for the resident therapies for wheelchair not provided. ecord indicated, R703 was lity on 11/28/18 with multiple fractures of ribs-left II, pain and history of falling. It to nic treatment record eekly skin check was done on address the bruise identified the abdomen. Indated, identified R703 had a wities of daily living deficit and with care and to restore elated to diagnosis fall rib, R703's revise care plan eted staff to "Monitor bruise to ower quadrant abdomen every Report > (increase) bruising, g, redness, or pain to MD/NP se practitioner)". p.m., R703 was observed in his room during an ntioned, he had bruise and ruise was an egg size dark eright side of abdomen. When R703 indicated, he does not		84			
	R703's progress no	te dated 12/3/18, at 10:15					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
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F 684	· · · · · · · · · · · · · · · · ·	~	F€	684		
	abdomen to mid low However, the media documentation of the R703's abdomen. R703's progress not read, "RLQ bruise; (centimeter) x 7.0 of superficial abrasion various shade of bruing proximal, lighter be the injury is consist of the transfer belt. (with) transfers & a bruise is not located body. No pain. The oriented) x 3. Paties bruise occurred. Pawas present. Patien No recent fall, at Toknow fall was at ho ambulation program (aspirin). Patient state to him. Patient states.	ne bruising on the right side of ote dated 12/4/18 at 1:43 p.m.,				
	read, "RLQ Abd: Refamily member [(F) conclusion that the transfer belt, during [F-A] indicated that to discuss the use a patient [F-A] that	ote dated 12/4/18 at 1:50 p.m., eported & reviewed bruise with -A]. [F-A] agreed with the bruise is related to the transfers and ambulation. the patient bruises easily. in the near future, she plans in the rear future, she plans with the anked writer for the call. [F-A] and no further questions."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
245518 B. WING	12/06/2018
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME STREET ADDRESS, CITY, STATE, ZIP C 8000 BASS LAKE ROAD NEW HOPE, MN 55428	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTION
F 684 Continued From page 20 F 684 On 12/4/18, at 3:33 p.m., nursing assistant (NA)-H stated, she just got report from the previous shift and license practical nurse (LPN)-C but no one reported the bruises that R703 sustained on right side of the abdomen. NA-H added, was not aware of the bruise. On 12/4/18 at 4:18 p.m., LPN-C indicated, she was not aware of R703 bruise on the right abdomen and the nursing assistant nor the previous shift has reported this to her during change of shift. On 12/4/18 at 4:20 p.m., after reviewed of R703's medical record, registered nurse (RN)-M verified R703's medical record. RN-M mentioned she was not aware of the R703 bruise. However, will assess and interview resident regarding the bruise. During a follow up interview with RN-M on 12/5/18 at 7:45 a.m., RN-M confirmed R703 had bruise on right side of abdomen, measured 4.5 cm x 7.0 cm about egg size purple in color with horizontal lines, soft to touch and resident denied pain. RN-M stated, she had assess and interviewed resident, updated F-A about the bruise and that they both thought is was from the transfer belt that was used by staff when transferring resident. On 12/5/18 at 8:35 a.m., RN-J indicated, she was not aware of R703's bruise prior to RN-M updating her. RN-J stated, the director of nursing	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 684	staff were trained to to the nurse manage document accurate progress note. On 12/5/18 at 11:07 (PT)-A mentioned, 11/29/18 and did not resident's abdomer R703 since then. On 12/5/18 at 11:17 (OT)-A indicated, start with dress some bruising, but the back. An undated facility	ge 21 In addition, RN-J indicated, oreport any new skin concerns ter or supervisor or DON and ly with description in the 7 a.m., physical therapist she evaluated resident on to notice any bruise on and has not worked with 7 a.m., the occupation therapy he had worked with R703 on and R703 required contact et and required moderate sing. OT-A stated she notice it was more to the side then on policy and procedure titled PROTOCOL FOR NURSES,		84			
	directed staff, "1. U House Supervisor u alterations which in ulcers, diabetic ulce blisters, lacerations Notify MD/NP to ob orders. 3. Notify the of the new wound/s skin alteration prog care] and complete (pressure ulcers/sk	pdate nurse manager and /or upon discovery of all new skin cludes bruises, pressure ers, vascular ulcers, skin tears, and surgical wounds. 2. tain new wound treatment eresident/legal representative skin alterations. 4. Complete ress note in PCC [point click a risk management UDA in tears)" Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 6	86		1/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L. IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
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F 686	Based on the com resident, the facilit (i) A resident receiprofessional stand pressure ulcers and ulcers unless the idemonstrates that (ii) A resident with necessary treatmed with professional supromote healing, promote healing to review the facility for the facility of the facility of the facility of the facility. The facility extensive assistant including dressing, mobility. The MDS diagnoses to include failure, peripherally circulation disorder outside of your head outside	orehensive assessment of a must ensure that- ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and pressure ulcers receives nt and services, consistent tandards of practice, to revent infection and prevent	F6	1) Resident R141 Prevalon placed on resident. Educat completed with NAR. 2) Staff will ensure that a re receives care to prevent pre and that a resident does no pressure ulcers unless it is 3) Nursing staff will be re-ective for residents with treatment prevent pressure ulcers. 4) Weekly audits will be corrobservation of residents rectreatment/services for the pressure ulcers to ensure the professional standards of professional standards of professional standards of professional compliance. 5) DON and/or designee is monitoring compliance. 6) The QAPI committee will direction or change when now will dictate the continuation of this monitoring process be compliance noted.	sident essure ulcers t develop unavoidable. ducated to ntions in place s/services to mpleted by ceiving revention of nat ractice are responsible for provide ecessary and or completion		

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F 686	understanding/com repositioning needs and a blood blister directed staff to ensemble of the bed, supporting the bed, supportin	pliance with turning and s, a history of pressure ulcers, on left great toe. The care plan sure R141 has his blue while in bed. 7 a.m. R141 was observed in ck with a footboard at the footing blankets off of feet, lon foam boots were not in boots were sitting on his 25 a.m. R141 remained in bed ck lying position. R141's its continued to be on his 51 a.m. A registered nurse was to have his foam boots he foam boots were worn to cers, primarily in the stated the use of the foam hended to be used as outlined 05 p.m. nursing assistant I's boots were not on at the ift. NA-H stated although she with change of incontinence sh to fully awaken resident to	F 6	886				

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	(FM)-B stated R141 times. FM-B stated last night to give hir and had not reapplication of press requested but was reques	was to wear his boots at all she had removed his boots in some time to move his feet ed them prior to leaving. Sted for proper use and ure relieving devices was not received. Azards/Supervision/Devices 1)(2) Its. Sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, and document ailed to implement	F 689	Cover placed to cup of resident R Care plan reviewed and current.	
	interventions listed spilling of hot bever (R109) reviewed for Findings include: R109's quarterly Mi 10/26/18, identified impairment with dia muscle weakness. R109 eats and drinl R109's care plan re R109 can feed self-	on the care plan to prevent ages for 1 of 5 residents accidents. nimum Data Set (MDS) dated R109 had severe cognitive gnosis of dementia and The MDS further identified		 Staff will ensure that the resident's environment remains as free of accidents/hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. A list was comple with all residents utilizing adaptive equipment and this was provided to department heads to share with their members. Staff will be re-educated that interventions listed on the care plan to prevent accidents must be followed. Weekly audits will be completed be observation of residents utilizing assistance. 	that eted staff

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F 689	R109 utilized a sposerved hot liquids R109's progress not during weekly shown noted on mid-thigh, that R109 reported ago, R109 is right hat R109 reported ago, R109 is right hat R109 was sitting at eating a Christmas regular uncovered her lap and on fron recreation coordinanurse (RN)-B, R109 and brought to her During observation R109 had spouted beverages in front of R109's progress not spill that was observation R109 had spouted beverages in front of R109's progress not spill that was observation R109's coffee spill that was observation R109's coffee spill that was observation R109's progress not spill that was observation R109'	uted mug with cover when ote dated 11/05/18, indicated over a fluid filled blister was. The progress note indicated she got burned a couple days handed and likes to drink hot ote indicated care plan revised hold lid for hot beverages. on 12/04/18, at 3:23 p.m. dining table in her wheelchair cookie, R109 dropped her coffee cup, spilling coffee on to fher shirt. Therapeutic litor (TC)-A notified registered 9 was removed from the table room to be changed. on 12/05/18, at 9:31 a.m. covered mug for her of her. otes failed to identify the coffee literate on 12/4/18. on 12/05/18, at 12:28 pm d not know about a coffee spill more information. of pm RN-C stated RN-A told spill was followed up on and ractitioner was notified today heck had been done and there	F 689	devices to ensure that the listed on the care plan are 4) DON and/or designee is monitoring compliance. 5) The QAPI committee will direction or change when n will dictate the continuation of this monitoring process compliance noted.	being followed. responsible for Il provide necessary and or completion		

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F 689	notified RN-B immesshe informed RN-B R-109's progress nompleted a skin as was in R-109's care covered mug with here covered as small found on inner side cleaned and a cool re-examination 2 here and no injuries were practitioner were up to a see the cool of the covered mug with here covered mug with here covered to be seen to be seen as a see that the covered mug with here covered to be seen to	ediately. RN-A went on to say to make a late entry in ote and confirmed she had ssessment. RN-A did state it e plan to use a spouted not liquids. ote marked late entry and 14:19 indicated on 12/04/18 pilled on R109's lap, the note 4 cm x 2 cm red area was of left breast. Area was cloth was applied. Upon ours later, red area was gone e observed. Family and nurse odated regarding the spill. 4 am R109's skin was and RN-A and RN-D, no were noted. on 12/06/18, at 8:54 am with erapeutic recreation staff just orint a new list before each click care which not only lists daptive equipment if needed. on 12/06/18, at 9:20 am RN-A cups with the cover come N-A went on to say it is also on fee time, the TC prints a daily at information on it. RN-A cups with lids should be it in the kitchenette.	F	889			
		a spouted cup with a lid meal ticket from the kitchen					

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F 689	Continued From pa		F 6	89			
	A policy was requeno policy received.	sted for following care plans,	F 6	90	1/15/19		
	resident who is con admission receives maintain continence	facility must ensure that itinent of bladder and bowel on services and assistance to e unless his or her clinical omes such that continence is					
	incontinence, base comprehensive assensure that- (i) A resident who e indwelling catheter resident's clinical or catheterization was (ii) A resident who e indwelling catheter is assessed for remas possible unless demonstrates that and (iii) A resident who receives appropriate prevent urinary traccontinence to the expensive assessed for the expensive appropriate and (iii) A resident who receives appropriate prevent urinary traccontinence to the expensive assessed for the expensive appropriate and (iii) A resident who receives appropriate appropriate to the expensive assessment as a second and the continence to the expensive assessment as a second and the continence as a second as a second and the continence as a second as a secon	enters the facility without an is not catheterized unless the condition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder are treatment and services to at infections and to restore xtent possible.					
	incontinence, base comprehensive ass	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel					

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F 690	receives appropriate restore as much no possible. This REQUIREMED by: Based on interview facility failed to enswas changed according of 3 residents (R99 Foley catheter. Findings include: R99 quarterly Minimal 10/25/18, indicated obstructive and reflection (UTI) prostatic hyperplas and chronic kidney was cognitively interview of R99's care plan pring has a Foley cauropathy, BPH, urimal R99 is being seen retention and UTI. Review of R99's On 10/31/18, directed urologist's office every for 28 days. R99 here	te treatment and services to ormal bowel function as NT is not met as evidenced w and document review, the ture that an indwelling catheter reding to physician orders for 1 b) reviewed with an indwelling mum Data Set (MDS) dated R99's diagnoses included lux uropathy (urine cannot rinary tract), history of urinary 0, and retention of urine, benign ia (BPH) (enlarged prostate) disease. MDS indicated R99 act. Inted on 12/06/18, indicated atheter due to obstructive mary retention and frequency. by a urologist and is at risk for Last hospitalized 8/8/18 with a reder Summary Report dated Foley to be changed at very month, starting on the 25th and a physician's order to	F 690	,	nts with opriate or ed to elling s. ed by ey s are onsible for ide sary and mpletion	
	10/31/18, directed urologist's office ever for 28 days. R99 h change 16F 5 cc be clogged and unable Review of R99's padated 11/28/18, ind	Foley to be changed at very month, starting on the 25th ad a physician's order to alloon as needed (PRN) if				

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTI		COM	E SURVEY IPLETED
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F F F C V S C V 1 h b C U C tl C U F C 1 tt N C h a v S S S S	when interviewed of stated he had to se catheter on 11/28/1 was to have a supra 12/07/18, but is not his cardiologist. Repeen over a month changed. R99 state urinary tract infections at heter getting pluthen ursing home he catheter in the past urologist every more countries and he was only seen for a catheter placement urologist had not specified for the suppointment administration of the suppointment book to the schedule lacked a featated an appointment catheduled and it metatated to the suppointment catheduled and it metatated an appointment at the catheduled at the catheduled and it metatated an appointment at the catheduled at the c	now and forego the supra ement and continue catheter		90			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
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F 690	would call the urolo if monthly changes could be done at the During interview on unit coordinator (HU goes to an outside and an order sheet to say at times they and recommendation stated the notes and to the nurse manage.	28 days. RN-E stated she gist office to follow up and see needed to be in office or if it	F 69	90		
	Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respira tracheostomy care The facility must enneeds respiratory care and tracheal scare, consistent wit practice, the compreare plan, the resid and 483.65 of this standard tracheal scare, consistent wit practice, the compreare plan, the resid and 483.65 of this standard tracket by: Based on observative review, the facility factorized the facility factorized the standard tracket in the	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences,	F 69	1) R195 tubing was changed and orders added to the EMAR for we tubing changes every Tuesday ni for all residents requiring oxygen nebulizers. 2) Staff will ensure that all resider requiring respiratory care will hav provided consistent with profession	eekly ght shift and nts e cares	1/15/19

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F 695	(MDS) dated 11/ 2 diagnosis of anxiet pulmonary disease congestive heart favascular disease (hospice for palliative therapy. R195's physician of R195 was to have 2-5 liters per minur comfort. R195 was liters of oxygen on R195's care plan of R195's need for ox During observation was resting in bed verbal, and had ox liters per minute. To dated. During observation R195's daughter and it was running and it was running During interview or registered nurse (Fisupposed to changed and state in use by R195. Rinew tubing change however it is not, as a soul and it was running to changed and state in use by R195. Rinew tubing change however it is not, as a soul and it was running to change however it is not as a soul and it was running to change however it is not as a soul and it was running to change however it is not as a s	6/18, indicated R195 has a ty, chronic obstructive e (COPD) requiring oxygen, ailure and (CHF), Peripheral PVD) and R195 was on we care receiving oxygen order dated 11/15/18, indicated oxygen per a nasal cannula at the as needed for respiratory sobserved to have between 2-3 per nasal cannula.	F6	st 3), re tu aı 4), re eı co E oı ca in w 5), m 6), di w of	tandards of practice. Nursing staff will be re-educally being must have them changed and documented on the EMAR/I) Weekly audits will be completed and sesidents on oxygen and nebulizations that tubing changes are completed and documented on MAR/ETAR. Weekly audits con new admission needing respare to ensure nursing orders and the EMAR/ETAR and documented to DON and/or designee is respanditoring compliance. The QAPI committee will province time to ensure the continuation or conference or change when necess ill dictate the continuation or conference of this monitoring process based ompliance noted.	lizer I weekly ETAR ted with zers to being the empleted iratory re placed ented onsible for vide sary and empletion	

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F 791 SS=D	During interview on director of nursing (usual practice to do change date in the was not any docum oxygen tubing was stated there is no poxygen tubing for return the manufacture of Home Oxygen Tubing replacing nasal candays. Do not use yodays. Routine/Emergency CFR(s): 483.55(b)(1) §483.55 Dental Ser The facility must as routine and 24-hour §483.55(b) (1) Must outside resource, in of this part, the follothe needs of each return to find the state plant (ii) Emergency dent §483.55(b)(2) Must assist the resident-(i) In making appoin	12/5/18, after 1:21p.m. the (DON) stated it is the facilities ocument new oxygen tubing TAR. The DON stated there ientation of when R195's lasted changed. The DON olicy or procedure on new esidents. If Nasal Cannula, Salter Labs, ing Bulletin recommends inula at least once every 14 our cannula for more than 30 or Dental Srvcs in NFs 1)-(5) Invices is ist residents in obtaining in emergency dental care. If Facilities. If provide or obtain from an accordance with §483.70(g) owing dental services to meet resident: ervices (to the extent covered in); and tal services; If in necessary or if requested, intments; and atransportation to and from the	F 6			1/15/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245518	B. WING) 06/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		00/2010
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F 791	residents with lost of dental services. If a 3 days, the facility is what they did to entand drink adequate services and the extended to the delay; §483.55(b)(4) Must circumstances whe dentures is the facincharge a resident for dentures determine policy to be the facincharge and wish to reimbursement of comedical expense under the transport of the extended to provide the policy of the expense	repromptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eately while awaiting dental stenuating circumstances that the loss or damage of lity's responsibility and may not or the loss or damage of lity's responsibility; and lity's responsibility; and lity's responsibility; and lassist residents who are participate to apply for lental services as an incurred ander the State plan. Note that the loss of damage of lental services as an incurred ander the State plan. The loss of damage of lental services for services as an incurred ander the state plan. The loss of damage of lental services for services as an incurred ander the state plan. The loss of damage of lental services for services as an incurred ander the state plan. The loss of damage of lity's responsibility; and lental services are incurred and document review the lental services for services for dental services for services and document review the lental services for services for dental services	F 79	1) Resident R64 was offered der services. Quarterly pain interview Balance and ROM, Oral/Dental s assessment was updated with sp questions regarding if the resider to be seen, last time see, and if rudoes not want to be seen, risks a benefits are verbalized. MDS car close without assessment questions answered. The assessment is confor all MDS except "end of PPS so Care conference summary assess updated to include documentation resident has been offered ancillat services. 2) Staff will assist resident in obta	tatus- V2 pecific nt wants esident and nnot ons being ompleted stay". ssment n that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245518	B. WING		C 12/06/2018	3
	PROVIDER OR SUPPLIER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 BASS LAKE ROAD IEW HOPE, MN 55428	, , , , , , , , , , , , , , , , , , , ,	
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	no answer to the question of the dentist. During an interview stated R64 needed R64's teeth were far had not been asked dentist. During an interview registered nurse (Rasked at care confedental services and the dentist we assist dentist. During an interview registered nurse (Rasked at care confedental services and the dentist we assist dentist. During an interview social worker (SW) box on the Care Coservices for R64. Seremember back in about dental services. During an interview RN-H stated the bound the dentist we assist dentist. During an interview about dental services for R64. Seremember back in a services for R64. Seremember back in the dential services as needed. A Dental Examination 12/13, indicated reservices as needed.	Summary form dated dicated if R64 was offered ervices for dental, vision, r psychology. on 12/3/18, at 4:04 p.m. R64 to see a dentist because Illing apart. R64 stated R64 d if R64 needed to see a on 12/5/18, at 1:27 p.m. N)-F stated residents are erences if they would like if the resident requests to see at in getting them to the on 12/6/18, at 10:38 a.mA stated I did not check the enference form for ancillary SW-A stated I do not October if I asked R64 or not es. on 12/6/18, at 2:40 p.m. x on the quarterly MDS dated en checked. RN-H stated I do R64 if dental services were	F 791	routine and 24 hour emergency decare. 3) Staff will be educated that all resare eligible to receive dental servic 4) Weekly audits will be completed resident/family interview and /or assessment completed to ensure ocare has been offered. 5) DON and/or designee is responsionitoring compliance. 6) The QAPI committee will provide direction or change when necessar will dictate the continuation or comof this monitoring process based or compliance noted.	sidents es. by dental sible for ery and pletion n the	
	Safe/Functional/Sa CFR(s): 483.90(i)	nitary/Comfortable Environ	F 921		1/15/19	9

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	COMI	SURVEY PLETED
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F 921	The facility must presanitary, and comforesidents, staff and This REQUIREMENT by: Based on observation documentation revial a residents wheel of 1 of 1 residents (R1 Findings include: R138's quarterly Midated 11/11/18, indivincluded, severely hypertension (elevate depression and Parneurological disease chair for mobility willocations. R138's care plan darequired extensive activities of daily lived During observation R138's wheelchair, white substance and substance on the frechair. During observation the dates of 12/3/18 continued to have a	nvironmental Conditions ovide a safe, functional, ortable environment for the public. NT is not met as evidenced tion, interview and ew the facility failed to ensure hair was clean and sanitary for 138) reviewed for environment. Inimum Data Sets (MDS) incated R138's diagnosis impaired cognition, ated blood pressure), richinson (chronic progressive e). R138 required a wheel th staff to propel to all ated 12/6/18, indicates R138 assistance with all his	F 921	1) Resident R138 wheelchair was cleaned. 2) Staff will ensure that residents a provided with a safe, functional, sa and comfortable environment. 3) Staff will be educated on the prowheelchair cleaning at St. Therese Hope SNF. 4) Weekly audits will be completed ensure that wheelchairs are being per facility protocol. 5) DON and/or designee is responsionitoring compliance. 6) The QAPI committee will provide direction or change when necessar will dictate the continuation or comof this monitoring process based or compliance noted.	nitary, cess of New to cleaned sible for e ry and pletion	
	During interview on	12/6/18, at 11:36 a.m. nurse				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
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F 921	and needs to be clean decreased practical numbelchair is dirty at LPN-B stated nurse wheel chair down wistated nursing has name is on the list, having been cleaned During record revies Schedule, R138's numbelchair washed done or clean. A facility policy for CR Resident-Care Item revised 2014, indicating reusable it equipment will be considered.	ated R138's wheelchair is dirty caned. 12/6/18, at 11:45 a.m. urse (LPN)-B stated R 138's and needs to be cleaned. Es are supposed to wipe the chen viably soiled. LPN-B a cleaning list and R138's however it is not initialed as a cleaning list and R138's however it is not initialed as a cleaning and Disinfection of its and Equipment dated ates resident-care equipment, tems and durable medical leaned and disinfected t recommendations for OSHA Bloodborne	F 92	1		

F55/8025

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245518 12/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY 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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 05, 2018. At the time of this survey, St. Therese Home 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) Standard 101, Life Safety Code (LSC), **EPOC** Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/03/2019

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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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245518 B. WING 12/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRFFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 IS NOT REQUIRED. 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. St Therese Home is a 3-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1968 and was determined to be of Type I (332) construction. In 1973, an addition was constructed to the 3rd floor that was determined to be of Type II (111) construction. In 1999, an addition was constructed to the west-side of the 1st floor that was determined to be of Type I (332). Another addition was constructed in 2003 to the 2nd and 3rd floor that was determined to be of Type I (332). Because the 3rd floor was determined to be Type II (111), the building was downgraded to Type II (111). Being that the construction type is allowed for an existing building of this height, the building is

Event ID: U9RL21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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K 521	automatic fire spring alarm system with corridors and space are monitored for a notification. The facility has a common census of 226 at time. The requirement a NOT MET as evided HVAC CFR(s): NFPA 101 HVAC Heating, ventilation	uilding. The building is fully iklered. The facility has a fire smoke detection in the es open to the corridors that automatic fire department apacity of 258 beds and had a me of the survey. It 42 CFR, Subpart 483.70(a) is enced by: In, and air conditioning shall d shall be installed in e manufacturer's	K 00			1/15/19
	by: Based on observation facility's heating, vein not in compliance 9.2, 19.5.2.1 and Noractice could effect Findings include: On a facility tour be	NT is not met as evidenced attion and staff interview, the entilation, and air conditioning the with the 2012 LSC NFPA 101 IFPA 90A. This deficient ct all 226 residents. Setween the hours of 10:00 AM December 05, 2018, it was		AA continuum Waiver is be for K521. Compliance with will cause an unreasonable accordance with SOM 2480 - The cost estimated for co system dated 4/8/2014 is 1 Financing costs at 5% add \$272,768. to the project Under current reimbursen estimate that it takes up to	this provision hardship in OC because: mplying HVAC 1,000000.00 an additional	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A: BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF T A G		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 521	Continued From page 4 K 521 personal have been trained and designated for conducting the fire watch procedure when necessary. Documentation of fire watch rounds are available for reviewThe fire department station is 2 miles away and has an average of 3 minute response timeThe fire alarm systems (pull stations, smoke/heat detection and notification devices) have been updated to include addressable technology throughout Monthly fire drills are conduced and documented on all 3 shifts for staffThe facility is inspected annually by a deputy from the MN fire marshal officeThe staffing ratio is 1 staff per 1.3 residents in a 24 hour period.		s are illes ute ons, ion lude it. ind f. by a ffice.				
	CFR(s): NFPA 101 Rubbish Chutes, In Chutes 2012 EXISTING (1) Any existing line pneumatic rubbish directly onto any coresistive constructions shall be provided was fire protection rationall comply with 9 (2) Any rubbish chupneumatic rubbish provided with autor in accordance with (3) Any trash chute collection room use	ite or linen chute, including and linen systems, shall be natic extinguishing protection	K	541			1/15/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245518 B. WING 12/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD ST THERESE HOME NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 541 Continued From page 5 K 541 laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced The door on the 2nd floor soiled linen Based on observation and staff interview, the chute in room 241 has been replaced with facility did not seal the vertical chute with the a fire door assembly Classified 'UL' Class appropriate fire protective rating in accordance B labeled: 1-1/2 hour fire rated. See with the 2012 LSC NFPA 101, 9,5. This deficient practice could effect all residents in the smoke addendum 2. compartment, Checking linen chute doors for code compliance will be included in the monthly Findings include: Preventative maintenance program. The Director of Plant Operations will review the Preventative Maintenance On a facility tour between the hours of 10:00 AM and 03:00 PM on December 05, 2018, it was entries monthly to assure compliance. revealed the door on the 2nd floor soiled linen. chute, in Room 241 did not self-close. This deficient practice was verified by the Director of Maintenance at the time of discovery. K 712 | Fire Drills K 712 1/15/19 SS=C 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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 26, 2018

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

Re: State Nursing Home Licensing Orders - Project Numbers S5518030, H5518082, H5518084, and H5518085

Dear Administrator:

The above facility was surveyed on December 3, 2018 through December 6, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5518082, H5518084, and H5518085. 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 <u>only a suggestion</u> 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

St Therese Home December 26, 2018 Page 2

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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us

Phone: (320) 223-7343 Fax: (320) 223-7348

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Alison Helm, Enforcement Specialist Licensing and Certification

Minnesota Department of Health P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

alison Helm

Email: alison.helm@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	; 6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE !	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall light form.	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In a several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item aring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/infelicensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/02/19

TITLE

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428 SUMMARY STATEMENT OF DEFICIENCIES REQUIREMENT OF DEFICIENCY BY THE PRECEDED BY THAN SOUTH PRICE BY THE PRICE OF THE PRICE OF THAN SHOULD BE REQUIRED BY THAN SHOULD BE REQUIRED BY THAN BE REQUIRED BY THAN BY		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER ST THERESE HOME 8000 BASS LAKE ROAD NEW HOPE, MIN \$5289 PROVIDERS PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PRETRY TAG CONTINUED From page 1 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. On 12/3/18 - 12/6/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. An investigation of complaint H5518082, H5518084, and H5518085 were completed at the time of the revisit. The complaints were substantiated. Correction order issued at MIN Rule# 4050.0520 subp. 1. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders suing 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 in." This column also includes the findings which are in violation of the state text. This column also includes the findings which are in violation of the state statute after the statement, "This Culter is not met as evidence by," Following the surveyors findings are the Suggested Method of Correction and			00261	B. WING			
ST THERESE HOME XUMINARY STATEMENT OF DEFICIENCIES TAGE TA	NAME OF I				CTATE ZID CODE	121	00/2010
X41 ID X41 ID X41 ID X41 ID X41 ID X41 ID X42 ID X43 ID X44 ID X	NAME OF I	PROVIDER OR SUPPLIER					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Continued From page 1 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 breastner process, under the health. On 12/3/18 - 12/6/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. An investigation of complaints were substantiated. Correction order issued at MN Rule# 4658.0520 subp.1. Please indicate in you relectronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 "10 Prefix Tag." The state statute/rule out of complaince is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the enter the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and	ST THEF	RESE HOME					
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. On 12/3/18 - 12/6/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. An investigation of complaint the518082, H5518084, and H5518085 were completed at the time of the revisit. The complaints were substantiated. Correction order issued at MN Rule# 4658.0520 subp. 1. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETE
PLEASE DISREGARD THE HEADING OF THE	2 000	Department of Hearyou electronically, is necessary for Star enter the word "context. You must then State licensure procompletion date, the corrected prior to elements of the following correction of contexts. The completion of contexts and H5518085 were revisit. The completion order is subp. 1. Please indicorrection order is subp. 1. Please indicorrection that you and identify the date. Minnesota Department of the State Licensing federal software. The assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of contexts of the statement of the statement of the State Statement of the Statement	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 8, surveyors of this visited the above provider and ction orders are issued. An applaint H5518082, H5518084, e completed at the time of the sints were substantiated. Sued at MN Rule# 4658.0520 cate in your electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting Correction Orders using ag numbers have been cota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the sis column also includes the n violation of the state statute is not met as wing the surveyors findings Method of Correction and rection.	2 000			

Minnesota Department of Health

STATE FORM U9RL11 If continuation sheet 2 of 37

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00004		B. WING		2
		00261			12/0	6/2018
	PROVIDER OR SUPPLIER		S LAKE RO	STATE, ZIP CODE An		
ST THER	ESE HOME		E, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	APPLIES TO FEDE THIS WILL APPEA THERE IS NO REG PLAN OF CORRECT	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			1/15/19
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observati review, the facility fa was changed in a ti residents (R195) re failed to ensure an maintained while se wheelchair for 1 of investigate bruising reviewed for non-pr	ent is not met as evidenced on, interview and document ailed to ensure oxygen tubing mely manor for 1 of 1 viewed for oxygen therapy, upright position was eated in an adaptive 2 residents (R116) failed to for 1 of 3 residents (R703) ressure related skin concerns ment interventions listed on the		Completed.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
					l l	c
		00261	B. WING		12/0	06/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S S LAKE RO	STATE, ZIP CODE		
ST THEF	RESE HOME		PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	830 Continued From page 3		2 830			
	care plan to prevent spilling of hot beverages for 1 of 5 residents (R109) reviewed for accidents.					
	Findings include:					
	(MDS) dated 11/ 26 diagnosis of anxiety pulmonary disease congestive heart fa vascular disease (F hospice for palliativ therapy.	change Minimum Data Sets 1/18, indicated R195 has a 1/2, chronic obstructive (COPD) requiring oxygen, illure and (CHF), Peripheral PVD) and R195 was on the care receiving oxygen				
	R195 was to have of 2-5 liters per minute	oxygen per a nasal cannula at e as needed for respiratory observed to have between 2-3				
	R195's care plan da R195's need for oxy	ated 10/19/18, did not address ygen.				
	was resting in bed i verbal, and had oxy	on 12/4/18, at 3:21 p.m. R195 n an upright position, non gen on per nasal cannula at 3 ne tubing for oxygen was not				
	R195's daughter ar R195's room. R195	on 12/5/18, at 1:05 p.m. Id other family friends were in Oxygen tubing is not dated at 2 liters per minute.				
	registered nurse (R supposed to change to be changed. RN-documentation in the	12/5/18, at 1:21 p.m. N)-K stated the night shift is e oxygen tubing when it is due -K stated there was no he treatment administration when the tubing had last been				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74401 1544	OF CONTROL	IDENTIFICATION NOMBER.	a. Bu i ld i ng:			
		00261	B. WING		12/0	; 6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROAPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	changed and stated in use by R195. Rinew tubing change however it is not, at the tubing for R195. During interview on director of nursing (usual practice to do change date in the was not any docum oxygen tubing was stated there is no poxygen tubing for re. The manufacture of Home Oxygen Tubing nasal candays. Do not use you days. R116's quarterly Mit 10/29/18, indicated impairment and receive with transfers and rediagnoses included chronic pain, a histofracture with routine R116's care plan dahad decreased molbalance, impaired of (Alzheimer's type), a history of falls, and care plan directed is recline (HBTR) character with change in the control of the cont	d no date on the current tubing N-K stated best practice is that is should be recorded in TAR, and RN-K did not know when was last changed. 12/5/18, after 1:21p.m. the (DON) stated it is the facilities ocument new oxygen tubing TAR. The DON stated there rentation of when R195's lasted changed. The DON olicy or procedure on new residents. In Nasal Cannula, Salter Labs, and Bulletin recommends and at least once every 14 our cannula for more than 30 minum Data Set (MDS) dated R116 had severe cognitive relived extensive assistance mobility. R116's medical at Alzheimer's, dementia, ory of falling, and a closed expending. The State of S/24/18, indicated R116 religion, dementia impaired vision, chronic pain, and a right femur fracture. The staff to use a high back tilt	2 830			
		oom in an adaptive wheelchair				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, ((0)	or conviction	IDENTIFICATION NO.	A. Building:			
		00261	B. WING		12/0	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	with a head and ne R116 was observed back of the chair ar of the chair. The he providing support to was present at an a was observed leanichair during music positioned to the rik knees pointing to the on the footrest. At the below the head sup R116's outer aspect observed extending when observed from On 12/04/18, at 3:4 seated in her wheel upright position with hand side of the chad/neck cushion support to the resid herself towards the cues, however, her by the head/neck substitution of the chair out head/neck cushion. On 12/05/18, at 10: seated in her wheel was sitting with her and upper body obside of the chair out head/neck cushion. Observed seated in positioned back and twisted to the right of the chair out head/neck cushion. Observed seated in positioned back and twisted to the right of the chair out head/neck cushion. Observed seated in positioned back and twisted to the right of the chair out head/neck cushion.	ack support cushion in place. If with her back resting on the ad curled over to the left side ad/neck support was not a R116. At 11:15 a.m. R116 activity in the day room. R116 approgram. R116's hips were ght side of the chair with a left side and her feet resting his time, R116's head was apport with no support present. It of her left upper body was goutside of the chair support in behind the wheelchair. 6 p.m. R116 was observed lichair. R116 is seated in an in her head leaning to the left air back. Although the is in place, it provides no ent. R116 was able to shift center of the chair with verbal head remained unsupported	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	; 6/2018
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	RESE HOME		S LAKE RO			
31 11121			PE, MN 5542			
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2 830	Continued From pa	ge 6	2 830			
	pressure for the sid	e she was leaning.				
	(RN)-E stated the w lengthened. RN-E r support as this was upper body. RN-E a	10 a.m. registered nurse wheelchair seat should be emoved the head/neck not supportive of resident's also elevated the arm rest on aced R116's left arm on the				
	the day room seate hips center and pos chair, with her uppe	20 a.m. R116 was observed in d in her wheel chair with her sitioned to the back of the er body leaning to the left. observed resting on her lap.				
		requested for the resident therapies for wheelchair not provided.				
	admitted to this faci diagnoses including side, diabetes type In addition, the elec- indicated R703's we	record indicated, R703 was fility on 11/28/18 with g multiple fractures of ribs-left II, pain and history of falling. Stronic treatment record eekly skin check was done on address the bruise identified the abdomen.				
	potential for an actineeded assistance maximal function refracture. In addition dated 12/4/18, directly RLQ Abd qd (right I day), until resolved.	ndated, identified R703 had a vities of daily living deficit and with care and to restore elated to diagnosis fall rib, R703's revise care plan oted staff to "Monitor bruise to ower quadrant abdomen every Report > (increase) bruising, g, redness, or pain to MD/NP ise practitioner)".				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00261	B. WING		12/0)6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THERESE HOME			S LAKE ROAPE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	sitting in wheelchair interview, R703 me lifted his shirt up. Be purple bruise on the asked how he got it know and denied part R703's progress no read, " Dark bruis abdomen, mid lower medical record lack bruising on the right R703's progress no	te dated 12/2/18, at 1:17 p.m. sing noted to lower left side of the back" However, the sed documentation of the the side of R703's abdomen.				
	abdomen to mid lov However, the medic	bruising noted to lower left ver back. Denies pain" cal record lacked ne bruising on the right side of				
	read, "RLQ bruise; (centimeter) x 7.0 c superficial abrasion various shade of br proximal, lighter bet The injury is consist of the transfer belt. (with) transfers & all bruise is not located body. No pain. The oriented) x 3. Patier bruise occurred. Pawas present. Patier No recent fall, at TC know fall was at hol ambulation program	the dated 12/4/18 at 1:43 p.m., measuring 4.5 cm m, (3) parallel horizontal lines, to Apex of the bruise, and uising (darker distally, lighter tween the horizontal lines). Itent w/ the position & location Patient is an assist of 1 w/mbulation. The location of the d in a suspicious area of the patient is A&O (alert and nt does not recall how the attent did not realized a bruise at stated that he bruises easily. CU (transition care unit). Last me. Recently started a n and currently taking ASA ares no one caused any harm				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00261	B. WING		12/0) 6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THER	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
		ed that he feels safe. DON updated. NP updated. Family				
	read, "RLQ Abd: Refamily member [(F)-conclusion that the transfer belt, during [F-A] indicated that [F-A] indicated that to discuss the use a patient [F-A] that	te dated 12/4/18 at 1:50 p.m., eported & reviewed bruise with A.]. [F-A] agreed with the bruise is related to the transfers and ambulation. the patient bruises easily. in the near future, she plans & risks/benefits of ASA with the anked writer for the call. [F-A] and no further questions."				
	(NA)-H stated, she previous shift and li but no one reported	p.m., nursing assistant just got report from the cense practical nurse (LPN)-C I the bruises that R703 side of the abdomen. NA-H are of the bruise.				
	was not aware of R abdomen and the n	p.m., LPN-C indicated, she 703 bruise on the right ursing assistant nor the eported this to her during				
	medical record, reg R703's medical rec not aware of the R7	p.m., after reviewed of R703's istered nurse (RN)-M verified ord. RN-M mentioned she was '03 bruise. However, will w resident regarding the				
	12/5/18 at 7:45 a.m bruise on right side	nterview with RN-M on ., RN-M confirmed R703 had of abdomen, measured 4.5 egg size purple in color with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	C 06/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA			
			PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	pain. RN-M stated, interviewed residen bruise and that they	t to touch and resident denied she had assess and t, updated F-A about the both thought is was from the as used by staff when t.				
	not aware of R703's updating her. RN-J and administrator h report incident was audits were initiated documented the brufurther reeducation, staff were trained to the nurse manage	a.m., RN-J indicated, she was bruise prior to RN-M stated, the director of nursing ad been updated. Facility done. Staff reeducation and d. Will meet with the staff that uising in the progress note for In addition, RN-J indicated, o report any new skin concerns er or supervisor or DON and ly with description in the				
	(PT)-A mentioned, s 11/29/18 and did no	a.m., physical therapist she evaluated resident on the total transfer on and has not worked with				
	(OT)-A indicated, sl 12/3/18 on toileting guarding to the toile assistant with dress	a.m., the occupation therapy ne had worked with R703 on and R703 required contact at and required moderate sing. OT-A stated she notice it was more to the side then on				
	SKIN INTEGRITY F directed staff, "1. U House Supervisor u alterations which in	poolicy and procedure titled PROTOCOL FOR NURSES, pdate nurse manager and /or upon discovery of all new skin cludes bruises, pressure ers, vascular ulcers, skin tears,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00261	B. WING			C 06/2018
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ST THEF	RESE HOME		SS LAKE ROA PE, MN 55428	_		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPR I ATE	(X5) COMPLETE DATE
2 830	blisters, lacerations Notify MD/NP to ob orders. 3. Notify the of the new wound/s skin alteration prog care] and complete (pressure ulcers/sk Based on observati review, the facility fainterventions listed spilling of hot bever (R109) reviewed for Findings include: R109's quarterly Mi 10/26/18, identified impairment with dia muscle weakness. R109 eats and drint R109's care plan re R109 can feed self- supervision at meal R109 utilized a spo- served hot liquids R109's progress not during weekly show noted on mid-thigh. that R109 reported ago, R109 is right ho coffee. Progress not for spouted cup with During observation R109 was sitting at eating a Christmas	and surgical wounds. 2. tain new wound treatment resident/legal representative kin alterations. 4. Complete ress note in PCC [point click a risk management UDA in tears)" on, interview, and document ailed to implement on the care plan to prevent rages for 1 of 5 residents				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COI	(X3) DATE SURVEY COMPLETED	
00261 B. WING 12	C /06/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 830 Continued From page 11 her lap and on front of her shirt. Therapeutic recreation coordinator (TC)-A notified registered nurse (RN)-B, R109 was removed from the table and brought to her room to be changed. During observation on 12/05/18, at 9:31 a.m. R109 had spouted covered mug for her beverages in front of her. R109's progress notes failed to identify the coffe spill that was observed on 12/4/18. When interviewed on 12/05/18, at 12:28 pm RN-C stated she did not know about a coffee spill and would find out more information. On 12/05/18, at 3:01 pm RN-C stated RN-A told her R109's coffee spill was followed up on and family and nurse practitioner was notified today on 12/05/18, skin check had been done and there was no redness or burns. When interviewed on 12/05/18, at 3:15 pm RN-A stated she spoke to TC-A, who told her that she notified RN-B immediately. RN-A went on to say she informed RN-B to make a late entry in R-109's progress note and confirmed she had completed a skin assessment. RN-A did state it was in R-109's care plan to use a spouted covered mug with hot liquids. R-109's progress note marked late entry and dated 12/05/18, at 14:19 indicated on 12/04/18 cup of coffee had spilled on R109's lap, the note also noted a small 4 cm x 2 cm red area was found on inner side of left breast. Area was cleaned and a cool cloth was applied. Upon re-examination 2 hours later, red area was gone and no injuries were observed. Family and nurse		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00261	B. WING			C 06/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ST THER	RESE HOME		SS LAKE ROA PE, MN 55428			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
		4 am R109's skin was and RN-A and RN-D, no were noted.				
	TC-B stated the the recently started to pactivity from point c	on 12/06/18, at 8:54 am with erapeutic recreation staff just orint a new list before each lick care which not only lists daptive equipment if needed.				
	stated the spouted from the kitchen, RI meal ticket. At coff diet list that has tha	on 12/06/18, at 9:20 am RN-A cups with the cover come N-A went on to say it is also on ee time, the TC prints a daily t information on it. RN-A cups with lids should be t in the kitchenette.				
	nursing assistant (Nat R-109 needed	on 12/06/18, at 10:08 am IA)-F stated she would know a spouted cup with a lid meal ticket from the kitchen plan.				
	A policy was reques no policy received.	sted for following care plans,				
	director of nursing (review and review f assessment for who tubing change proc and skin changes a The DON or design perform audits to er each of these areas	HOD OF CORRECTION: The SON) and/or designee could acility policies regarding eelchair position, oxygen edures, monitoring of bruising nd accident prevention/safety. ee could educate staff, nsure care needs are met in s. The DON or and report ties quality assurance (QA)				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
		00261	B. WING		12/0	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROAPE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	committee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/15/19
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	by: Based on observati review the facility fa (pressure relieving consistently to redu	on, interview and document ailed to ensure Prevalon boots foam boots) were used to pressure for 1 of 3 viewed for pressure ulcers.		Completed.		
	Findings include:					
	(MDS) dated 11/16/	change Minimum Data Set 118 indicated R141 had e impairment and required				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00261	B. WING		12/0)6/2018
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
ST THEF	RESE HOME		S LAKE RO			
	OURANA DV OTA		PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 14	2 900			
	including dressing, mobility. The MDS in diagnoses to includ failure, peripheral vecirculation disorder outside of your hear	ee with activities of daily living grooming, bathing, and identified R141's medical e: cancer, anemia, heart ascular disease (A blood that causes the blood vessels rt and brain to narrow, block, s, right hip dislocation, arthritis,				
	R141 was at risk fo related to bowel inc related to right hip of understanding/com repositioning needs and a blood blister of	pliance with turning and s, a history of pressure ulcers, on left great toe. The care plan sure R141 has his blue				
	bed lying on his bac of the bed, supporti however, his Preval	7 a.m. R141 was observed in ck with a footboard at the foot ng blankets off of feet, lon foam boots were not in pots were sitting on his				
	at this time, in a bad	25 a.m. R141 remained in bed ck lying position. R141's ts continued to be on his				
	(RN)-L stated R141 on while in bed as t prevent pressure ul heels/ankles. RN-E	51 a.m. A registered nurse was to have his foam boots he foam boots were worn to cers, primarily in the stated the use of the foam nended to be used as outlined				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	6/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	On 12/06/18, at 12: (NA)-H stated R141 beginning of her sh had assisted R41 w brief, she did not wi ask if he would weat On 12/06/18, at 12: boots were to be in if personal cares we boots should have to the control of the control o	05 p.m. nursing assistant I's boots were not on at the ift. NA-H stated although she vith change of incontinence ish to fully awaken resident to ar his boots. 09 p.m. RN-L stated R141's place at all times. RN-L stated ere completed, R141's foam been applied at that time. 59 p.m. family member I was to wear his boots at all she had removed his boots m some time to move his feet ed them prior to leaving. sted for proper use and sure relieving devices was	2 900			
	they are receiving the treatment/services of from developing and pressure ulcers. The designee, could condelivery of care; to deservices are implended pressure ulcer developments.	he necessary to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
2 910	(21) days. MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			1/15/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		00261	B. WING		1	6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 16	2 910			
	have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ig catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder treatment and services to it infections and to restore as er function as possible.				
	by: Based on interview facility failed to ens was changed accor of 3 residents (R99 Foley catheter. Findings include: R99 quarterly Minin 10/25/18, indicated obstructive and refl drain through the un tract infection (UTI) prostatic hyperplasi and chronic kidney was cognitively inta	and document review, the ure that an indwelling catheter ding to physician orders for 1) reviewed with an indwelling num Data Set (MDS) dated R99's diagnoses included ux uropathy (urine cannot rinary tract), history of urinary, and retention of urine, benign ia (BPH) (enlarged prostate) disease. MDS indicated R99 ct.		Completed.		
		nted on 12/06/18, indicated theter due to obstructive				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00261	B. WING			C 06/2018
ST THERESE HOME 8000 BAS			DRESS, CITY, S' S LAKE ROA PE, MN 55428			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	R99 is being seen by retention and UTI. UTI. Review of R99's Or 10/31/18, directed Furologist's office experience of 28 days. R99 had change 16F 5 cc backlogged and unables of the compact of the compa	lary retention and frequency. By a urologist and is at risk for Last hospitalized 8/8/18 with a der Summary Report dated Foley to be changed at ery month, starting on the 25th ad a physician's order to alloon as needed (PRN) if a to flush. Itient visit note from urologist icated if there are any concerns, would continue now and forego the supralement and continue catheter	2 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00261	B. WING		l l	C 06/2018
	OF PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S S LAKE ROA PE, MN 5542			
(X4) I PREF TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 9	RN-E went on to sa canceled for the su 11/30/18. RN-E loc treatment administr November 2018, whome per the PRN appointment book to was scheduled for a schedule lacked and stated an appointm scheduled and it mustated R99's ETAR be changed every 2 would call the urolo if monthly changes could be done at the During interview on unit coordinator (Hugoes to an outside and an order sheet to say at times they and recommendation stated the notes and to the nurse manage put in any orders or A policy was request SUGGESTED MET The director of nurse all physician orders ordered referrals are ordered referrals are ordered referrals are ordered referrals are nursing or designed.	poken to the cardiologist. By the surgery had been pra pubic catheter on oked at the electronic ration record (ETAR) for hich indicated R99's last as on 11/02/18 at the nursing order. RN-E checked the o see if a urology appointment a catheter change, the future appointment. RN-E ent should have been just have been missed. RN-E indicated the catheter should 28 days. RN-E stated she gist office to follow up and see needed to be in office or if it	2 910			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00004	B. WING		40/0	
		00261			12/0	6/2018
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S S LAKE RO	STATE, ZIP CODE		
ST THER	RESE HOME		E, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 19	2 910			
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			1/15/19
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observation review the facility far personal grooming R141) reviewed for	ent is not met as evidenced on, interview, and document ailed to provide routine for 2 of 4 residents (R151, activities of daily living (ADL's) endent on staff for their care.		Completed.		
	Findings include:					
	R151's diagnosis in kidney disease, and	cluded diabetes, chronic d dementia.				
	11/18/18, indicated impaired. R151's M	nimum Data Set (MDS) dated R151 was cognitively MDS indicated R151 needed be from staff with personal				
		ated 11/19/18, indicated R151 sistance from one staff for ene needs.				
	During an observati	ion on 12/4/18, at 9:37 a.m.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00261			12/0)6/2018
NAME OF	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 12/0	0/2010
ST THEF	RESE HOME		S LAKE RO			
	CUMMA DV CTA		PE, MN 5542		ON	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 20	2 920			
		nately 15 white chin hairs 1/4 n. R151 stated it bothered nairs.				
	3:36 p.m. and 12/5/	observation on 12/4/18, at 18, at 7:09 a.m. R151 /4 to 1/2 inch long white chin				
	nursing assistant (Nassisting R151 with R151 to the sink in brushing R151's tee hair, took the hair of the garbage and the and threw it in the g	ion on 12/5/18, at 7:46 a.m. NA)-A and NA-C where morning cares. NA-A brought the room and assisted with eth. NA-A combed R151's ut of the comb and threw it in en took the disposable razor parbage. R151 chin hairs were A-A took R151 to the dining				
	NA-C stated we showant to be shaved,	on 12/5/18, at 8:33 a.m. buld shave the residents who even the women. NA-C e a disposable razor for the				
	stated female resid	on 12/6/18, at 8:23 a.m. NA-A ents should be shaved if they A-A confirmed R151 had not emoved prior to breakfast.				
	licensed practical n morning cares the e shave the residents	on 12/6/18, at 9:28 a.m. urse (LPN)-A stated with expectation of staff was to who were in need of shaving. does allow the staff to shave				
		on 12/6/18, at 1:32 p.m. the DON) stated if female				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00261	B. WING			C 06/2018
	PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 920	residents want chin should be doing that we should have offer hairs cleaned up. A facility policy was provided regarding R141's significant of (MDS) dated 11/16/significant cognitive extensive assistance including dressing, mobility. The MDS is diagnoses to includ diabetes, obstructive right hip dislocation R141's care plan reference R141 had an indwest urinary retention and may increase his rist tract infections. R14 incontinent of bowe was used. R141's of was at risk for deverto bowel incontiner to right hip dislocation understanding/com repositioning needs ulcers and had a blot toe. The care plan of has his blue Prevaled On 12/06/18, at 8:3 his room, in bed with head of the bed was 45 degree angle. A pronounced upon experience of the standard pronounce of the	hairs cleaned up then we at for them. The DON stated ered R151 to have the chin requested, however none was personal cares. Thange Minimum Data Set that indicated R141 had a impairment and required the with activities of daily living grooming, bathing, and identified R141's medical ere anemia, heart failure, the uropathy, urinary retention, arthritis, and pain. Evised on 12/3/18, indicated alling Foley catheter related dobstructive uropathy which the sk for recurrence for urinary that was also identified as all and an incontinence brief that are plan also indicated R141 eloping a pressure ulcer related ince, decreased mobility related on, lack of pliance with turning and the state of the pliance with turning and the state of the staff to ensure R141 on boots on while in bed. 7 a.m. R141 was observed in the his eyes closed. R141's selevated to approximately a	2 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		00261	B. WING			C 06/2018
	PROVIDER OR SUPPLIER	8000 BAS	DRESS, CITY, S S LAKE ROA PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETE DATE
2 920	covered and hangir foam boots were in On 12/06/18, at 11:: his room resting un R141's eyes were of was observed to att connected to the be pronounced urinary R141's foam boots On 12/06/18, at 11:: (RN)-L stated she of RN-E joined survey noted the urinary of be bypassing of the catheter) which was change the catheter provision of care for should not be an of RN-L also stated the of an infection or debypassing was noted the nurse as the catheter bypassing wet was unconstituted by the catheter bypassing wet was unconstituted bypassing wet was unconstitut	ge 22 Ig on the bed frame. R141's the chair next to the bed. 25 a.m. R141 was observed in der the covers on his bed. Hosed. Urinary catheter tubing ach to bed bag which was ed and was covered. A more odor was noted at this time. It is remained on the chair. 51 a.m. registered nurse ould smell a urinary odor. Find or and RN-L in the room and for. RN-L stated there could catheter (Leaking around the sindicative of the need to r. RN-L proceeded with r. R141. RN-L stated there for as it was a closed system. The odor could indicate the signs end this should be reported to the the was not functioning ed she had not been informed assing. RN-L also commented of the sign on the could cause well as the odor being and adding no one wants to stay a smells. RN-L stated R141's be in place on both feet when we to the potential for skin. 55 p.m. nursing assistant had provided R141 with its morning. NA-H stated the wed with provision of personal II noticeable. NA-H stated she	2 920			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	0. 0020		a. Building:			
		00261	B. WING		12/0	; 6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE RO			
040.15	CHMMADV CTA		PE, MN 5542		ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 23	2 920			
	foam boots were not she did not wish to wished to wear his she had performed pericare for inconting. On 12/06/18, at 12: (FM)-B stated R14 catheter for over six urinary tract infection observed urinary second the urine stated she had not today but stated R1 whole thing." FM-A the presence of a posmell urine in the roof FM-B stated she had she had she had stated she had she had she had stated she had sh	59 p.m. family member I has had his indwelling K months and has experienced ons. FM-B stated she has rediment in the tubing and has to be dark in color. FM-B observed a personal odor 41 would be "offended by the stated "I would be upset by rersonal odor if others could room." ad removed R141's boots last the foam boots were in place				
		o Foley catheter use and how was requested, but not				
	The director of nursidevelop/revise pert related to grooming grooming needs are importance of groomaudit could be repo	THOD OF CORRECTION: sing and/or designee could inent policies and procedures i, audit resident care to ensure e met and educate staff on the ming needs. The results of the rted during the quarterly ommittee meetings.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING		С	
		00261	B. WING		12/0	6/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST THER	RESE HOME		SLAKE ROA PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21330	Continued From pa	ge 24	21330			
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser		21330			1/15/19
	must be referred fo unless the resident examination within admission. B. After the ininursing home must resident wants to se any necessary help at least an annual be annual dental check one year from the examination or with	ental visit. The sys after admission, a resident of an initial dental examination has received a dental the six months before to the six months before to make the appointment, on the system of the analysis. This opportunity for an action was to the provided to make the appointment, on the system of the initial dental in one year from the date of the within the six months				
	by: Based on interview facility failed to prov	and document review the vide routine dental services for 64) reviewed for dental		Completed.		
	Findings include:					
	disease, and depre	luded ulcerative colitis, liver ssion. A quarterly Minimum ted 10/3/18, indicated R64's t.				
	(range of motion); (n Interview; Balance and ROM Dral/Dental Status-V2 dated R64 was not asked does the				

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Continued From page 25 resident need or want a dental exam? There was no answer to the question on the form. A Care Conference Summary form dated 10/16/18, did not indicated if R64 was offered ancillary medical services for dental, vision, hearing, podiatry, or psychology. During an interview on 12/3/18, at 4:04 p.m. R64 stated R64 had not been asked if R64 needed to see a dentist because R64's teeth were falling apart. R64 stated R64 had not been asked if R64 needed to see a dentist. During an interview on 12/5/18, at 1:27 p.m. registered nurse (RN)-F stated residents are asked at care conferences if they would like dental services and if the resident requests to see the dentist we assist in getting them to the dentist. During an interview on 12/6/18, at 10:38 a.m. social worker (SW)-A stated I did not check the box on the Care Conference form for ancillary services for R64. SW-A stated I do not remember back in October if I asked R64 or not about dental services. During an interview on 12/6/18, at 2:40 p.m. RN-H stated the box on the quarterly MDS dated 10/3/18, had not been checked. RN-H stated I do not know if I asked R64 if dental services were needed. A Dental Examination/Assessment policy dated	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
STTHERES HOME NUMMARY STATEMENT OF DEFICIENCIES CRAYLO DEFICIENCY MUST BE PRECEDED BY FULL TAG Interview on 12/3/18, at 1:27 p.m. registered nurse (RIM) – Stated resident sae a sked at care conferences if they would like dentist. During an interview on 12/5/18, at 1:27 p.m. registered nurse (RIM) – Stated resident sae asked at care conferences if they would like dentist. During an interview on 12/6/18, at 1:27 p.m. registered nurse (RIM) – Stated resident sae set the dentist we assist in getting them to the dentist. During an interview on 12/6/18, at 1:27 p.m. registered nurse (RIM) – Stated resident sae a sked at care conferences if they would like dentist. During an interview on 12/6/18, at 1:27 p.m. registered nurse (RIM) – Stated resident sae asked at care conference from for ancillary services for R64. SW-A stated I did not check the box on the Care Conference form for ancillary services for R64. SW-A stated I do not remember back in October if I asked R64 or not about dental services. During an interview on 12/6/18, at 2:40 p.m. RN-H stated the box on the quarterly MDS dated 10/3/18, had not been checked. RN-H stated I do not know if I asked R64 if dental services were needed. A Dental Examination/Assessment policy dated A Dental Examination A Den			00261	B. WING			_
CAJID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION CASC CACHE CHECKEN WILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TRACE CACHE CHECKEN WILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			8000 BAS	S LAKE RO	AD		
resident need or want a dental exam? There was no answer to the question on the form. A Care Conference Summary form dated 10/16/18, did not indicated if R64 was offered ancillary medical services for dental, vision, hearing, podiatry, or psychology. During an interview on 12/3/18, at 4:04 p.m. R64 stated R64 needed to see a dentist because R64's teeth were falling apart. R64 stated R64 had not been asked if R64 needed to see a dentist. During an interview on 12/5/18, at 1:27 p.m. registered nurse (RN)-F stated residents are asked at care conferences if they would like dental services and if the resident requests to see the dentist we assist in getting them to the dentist. During an interview on 12/6/18, at 10:38 a.m. social worker (SW)-A stated I did not check the box on the Care Conference form for ancillary services for R64. SW-A stated I do not remember back in October if I asked R64 or not about dental services. During an interview on 12/6/18, at 2:40 p.m. RN-H stated the box on the quarterly MDS dated 10/3/18, had not been checked. RN-H stated I do not know if I asked R64 if dental services were needed. A Dental Examination/Assessment policy dated	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNCES TO THE APPR	JLD BE	COMPLETE
12/13, indicated residents shall be offered dental services as needed. SUGGESTED METHOD OF CORRECTION:	21330	resident need or wano answer to the quantum of the	ant a dental exam? There was lestion on the form. Summary form dated dicated if R64 was offered ervices for dental, vision, repsychology. on 12/3/18, at 4:04 p.m. R64 to see a dentist because lling apart. R64 stated R64 dif R64 needed to see a on 12/5/18, at 1:27 p.m. N)-F stated residents are erences if they would like if the resident requests to see at in getting them to the on 12/6/18, at 10:38 a.mA stated I did not check the enference form for ancillary SW-A stated I do not Doctober if I asked R64 or not less. on 12/6/18, at 2:40 p.m. x on the quarterly MDS dated en checked. RN-H stated I do R64 if dental services were	21330			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	
		00261	B. WING		12/0	6/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THER	ESE HOME		S LAKE ROA E, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21330	Continued From pa	ge 26	21330			
	staff regarding the residents. The dire	sing or designee could educate need to offer dental services to ctor of nursing or designee auditing system to monitor e.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21665	MN Rule 4658.1400	Physical Environment	21665			1/15/19
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				
	by: Based on observati documentation revie a residents wheel c	ent is not met as evidenced on, interview and ew the facility failed to ensure hair was clean and sanitary for 138) reviewed for environment.		Completed.		
	Findings include:					
	dated 11/11/18, indi included, severely hypertension (eleva depression and Par neurological diseas chair for mobility willocations.	ated blood pressure), kinson (chronic progressive e). R138 required a wheel th staff to propel to all				
		ated 12/6/18, indicates R138 assistance with all his				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00261	B. WING		12/0	6/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S S LAKE RO	STATE, ZIP CODE		
ST THER	ST THERESE HOME NEW HO					
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 27	21665			
	activities of daily livi	ing.				
	R138's wheelchair, white substance an	on 12/3/18, when observing it was noted to have dried d a sticky looking clear ame and covers of the wheel				
	the dates of 12/3/18 continued to have a	of R138's wheelchair during 3 through 12/6/18, R138 an unclean wheelchair with old d liquid on the chair.				
		12/6/18, at 11:36 a.m. nurse ated R138's wheelchair is dirty caned.				
	licensed practical n wheelchair is dirty a LPN-B stated nurse wheel chair down w stated nursing has	12/6/18, at 11:45 a.m. urse (LPN)-B stated R 138's and needs to be cleaned. es are supposed to wipe the when viably soiled. LPN-B a cleaning list and R138's however it is not initialed as ed.				
	Schedule, R138's n	w of the Wheelchair Washing ame was on the list to have , however it is not initialed as				
	Resident-Care Item revised 2014, indica including reusable i equipment will be c					

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00261	B. WING		12/0)6/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 1210	012010	
ST THEF	RESE HOME		S LAKE RO PE, MN 5542				
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21665	Continued From pa	ge 28	21665				
	educate staff regard clean, functional an DON or designee, of maintenance and he periodic audits of an ensure a safe, clean	sing (DON) or designee, could ding the importance of a safe, d homelike environment. The could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
21805	MN St. Statute 144. Residents of HC Fa	651 Subd. 5 Patients & ac.Bill of Rights	21805			1/15/19	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observati review, the facility fa provided care in a c from personal odor	ent is not met as evidenced on, interview and document ailed to ensure residents were lignified manner, and free for 2 of 5 residents (R705 and theters and were reviewed for e.		Completed.			
	Findings include:						
	recently admitted to included overactive	ecord indicated, R705 was this facility with diagnosis that bladder, malignant neoplasm on's disease, major and hypertension.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		С				
		00261	D. WING		12/0	6/2018
NAME OF	PROV I DER OR SUPPL I ER			STATE, ZIP CODE		
ST THERESE HOME			S LAKE ROA PE, MN 5542			
(X4) I D	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21805	Continued From pa	ge 29	21805			
	sitting in wheelchair uncovered urinary of hooked to it hanging chair. R705's door wopen, as staff and wa personal aide (PAtime. The urinary dicontain approximat R705 verbalized that hanging on the reclindicated, facility sta7:30 a.m., but did nidrainage bag.	a.m., R705 was observed reating breakfast with an drainage bag with condom g on the left end of the recliner was observed to be wide visitors passed by. There was a) sitting in the room at the rainage bag was observed to ely 200 milliliters of urine. At drainage bag with urine iner was bothersome. The PA aff get resident ready around ot empty nor clean the				
	between 8:40 a.m. observed sitting in vurinary drainage bathanging on the left R705's door was obstaff (NA-D, NA-E, passed by. The urinobserved to contain of urine. At 9:07 a.m. and transferred R70 recliner chair but dicclean the drainage left side of the reclinindicated, she reminand cleaning the drempty or clean the 9:16 a.m., R705 ex bag with urine hange On 12/6/18 observations observed sitting in robserved sitting in robserved sitting in robserved sitting in robserved.	ations were conducted and 9:08 a.m., R705 was still wheelchair with an uncovered g with condom hooked to it end of the recliner chair. Served to be wide open, as RN-I), residents and visitors hary drainage bag was a approximately 200 milliliters in., NA-D went to R705's room 05 from the wheel chair to the d not remove, empty and bag that was hanging on the her chair. At 9:15 a.m., PA inded NA-D about emptying ainage bag but NA-D did not drainage bag with urine. At pressed dislike of drainage ging on the recliner chair. Ations were conducted and 10:35 a.m., R705 was still recliner chair with an drainage bag with condom				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG COMPLETE DEFICIENCY 21805 Continued From page 30 hooked to it hanging on the left side of the recliner chair with urine. At 19:36 a.m., the speech language pathologist (SLP) went to resident room and the drainage bag was still hanging on the recliner chair. At 10:21 a.m., RN-I went to R705's room to answer call light and R705 needed assistant with the urinal to urinate and RN-I assisted R705 but did not empty the drainage bag with condom hooked to it with 200 milliliters of urine was hanging on the right end of the recliner, RN-I removed it, emptied, clean and stored drainage	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	1 ` '		· /	X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8000 BASS LAKE ROAD NEW HOPE, MN 55428 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 30 hooked to it hanging on the left side of the recliner chair with urine. At 9:36 a.m., the speech language pathologist (SLP) went to resident room and the drainage bag was still hanging on the recliner chair. At 10:21 a.m., RN-I went to R705's room to answer call light and R705 needed assistant with the urinal to urinate and RN-I assisted R705 but did not empty the drainage bag with 200 milliliter of urine. At 10:35 a.m., RN-I confirmed the uncovered drainage bag with condom hooked to it with 200 milliliters of urine was hanging on the right end of the recliner. RN-I removed it, emptied, clean and stored drainage				A. BOILDING.		, ا	,	
ST THERESE HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 30 hooked to it hanging on the left side of the recliner chair with urine. At 9:36 a.m., the speech language pathologist (SLP) went to resident room and the drainage bag was still hanging on the recliner chair. At 10:21 a.m., RN-I went to R705's room to answer call light and R705 needed assistant with the urinal to urinate and RN-I assisted R705 but did not empty the drainage bag with condom hooked to it with 200 milliliters of urine was hanging on the right end of the recliner. RN-I removed it, emptied, clean and stored drainage			00261	B. WING		1		
ST THERESE HOME NEW HOPE, MN 55428	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21805 Continued From page 30 hooked to it hanging on the left side of the recliner chair with urine. At 9:36 a.m., the speech language pathologist (SLP) went to resident room and the drainage bag was still hanging on the recliner chair. At 10:21 a.m., RN-I went to R705's room to answer call light and R705 needed assistant with the urinal to urinate and RN-I assisted R705 but did not empty the drainage bag with 200 milliliter of urine. At 10:35 a.m., RN-I confirmed the uncovered drainage bag with condom hooked to it with 200 milliliters of urine was hanging on the right end of the recliner. RN-I removed it, emptied, clean and stored drainage	ST THEF	RESE HOME						
hooked to it hanging on the left side of the recliner chair with urine. At 9:36 a.m., the speech language pathologist (SLP) went to resident room and the drainage bag was still hanging on the recliner chair. At 10:21 a.m., RN-I went to R705's room to answer call light and R705 needed assistant with the urinal to urinate and RN-I assisted R705 but did not empty the drainage bag with 200 milliliter of urine. At 10:35 a.m., RN-I confirmed the uncovered drainage bag with condom hooked to it with 200 milliliters of urine was hanging on the right end of the recliner. RN-I removed it, emptied, clean and stored drainage	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR			(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE	
bag. At 11:20 a.m., RN-I stated, occupational therapist (OT) assisted R705 with morning cares and did not do the catheter care as OT suppose to do. RN-I added, she spoke with OT regarding the importance of catheter care. During interview on 12/6/18, at 11:23 a.m. RN-J indicated, the expectation was R705's drainage bag should be covered with black cover when up in the chair or wheelchair and R705 drainage bag should have been emptied, rinsed and put away to maintain resident's dignity and privacy. R141's significant change Minimum Data Set (MDS) dated 11/16/18 indicated R141 had significant cognitive impairment and required extensive assistance with activities of daily living including dressing, grooming, bathing, and mobility. The MDS identified R141's medical diagnoses to include: anemia, heart failure, diabetes, obstructive uropathy, urinary retention, right hip dislocation, arthritis, and pain. R141's care plan revised on 12/3/18, indicated R141 had an indwelling Foley catheter related urinary retention and obstructive uropathy which	21805	hooked to it hanging recliner chair with use language pathologis and the drainage by recliner chair. At 10 room to answer call assistant with the use assisted R705 but of with 200 milliliter of confirmed the unco condom hooked to was hanging on the removed it, emptied bag. At 11:20 a.m., therapist (OT) assistant did not do the of to do. RN-I added, the importance of condicated, the expection of the chair or wheely as should be covered in the chair or wheely as should have been esto maintain resident (MDS) dated 11/16/significant cognitive extensive assistance including dressing, mobility. The MDS is diagnoses to includ diabetes, obstructive right hip dislocation R141's care plan re R141 had an indwer and the diagnoses to include the care plan re R141 had an indwer and the care plan re R141 had a	g on the left side of the rine. At 9:36 a.m., the speech st (SLP) went to resident room ag was still hanging on the 1:21 a.m., RN-I went to R705's I light and R705 needed rinal to urinate and RN-I did not empty the drainage bag urine. At 10:35 a.m., RN-I wered drainage bag with it with 200 milliliters of urine e right end of the recliner. RN-I d, clean and stored drainage RN-I stated, occupational sted R705 with morning cares eatheter care as OT suppose she spoke with OT regarding atheter care. 12/6/18, at 11:23 a.m. RN-J etation was R705's drainage ered with black cover when up elchair and R705 drainage bag emptied, rinsed and put away t's dignity and privacy. Change Minimum Data Set 18 indicated R141 had a impairment and required a with activities of daily living grooming, bathing, and identified R141's medical e: anemia, heart failure, a uropathy, urinary retention, a arthritis, and pain.	21805				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00261	B. WING		12/0	6/2018
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ST THEF	RESE HOME		S LAKE ROA E, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21805	tract infections. R14	ge 31 I1 was also identified as I and an incontinence brief	21805			
	was used. The care with catheter cares The care plan direc	e plan directed staff to to assist every shift and as needed. ted staff to manage catheter medical doctor (MD) or nurse				
	his room, in bed wit head of the bed wa 45 degree angle. A pronounced upon e R141's urinary cath	7 a.m. R141 was observed in h his eyes closed. R141's selevated to approximately a smell of urine was ntering the resident room. eter bed bag was observed ag on the bed frame.				
	his room resting un R141's eyes were of was observed to att connected to the be	25 a.m. R141 was observed in der the covers on his bed. losed. Urinary catheter tubing ach to bed bag which was ed and was covered. A more odor was noted at this time.				
	(RN)-L stated she of RN-E joined survey noted the urinary of coming from the blacatheter bag. RN-L bypassing of the cacatheter) which was change the catheter provision of care for should not be an or RN-L also stated than infection or dehy bypassing was noted the nurse as the caproperly. RN-L stated	51 a.m. registered nurse could smell a urinary odor. or and RN-L in the room and dor. RN-E thought it may be ack cloth bag covering the stated there could be theter (Leaking around the sindicative of the need to r. RN-L proceeded with r R141. RN-L stated there dor as it was a closed system. The coordinate of the region of dration. RN-L stated when ad this should be reported to the ter was not functioning and she had not been informed assing. RN-L also commented				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			ATE SURVEY OMPLETED	
	00004		B. WING		C		
		00261	ļ.		12/0	6/2018	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S S LAKE RO	STATE, ZIP CODE			
ST THEF	RESE HOME		S LAKE KO/ PE, MN 5542				
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 32	21805				
	that being wet was cause skin breakdo noticeable to others in the room with the	uncomfortable and could own, as well as the odor being s, adding no one wants to stay e smells.					
	(NA)-H stated she I personal hygiene the odor of urine impro- hygiene but was sti	D5 p.m. nursing assistant nad provided R141 with nis morning. NA-H stated the ved with provision of personal II noticeable. NA-H stated she of the urinary odor and the theter.					
	stated R141 has had over six months and tract infections. F-I urinary sediment in the urine to be dark not observed a pers R141 would be "off FM-A stated" I would	59 p.m. family member (F)-B and his indwelling catheter for d has experienced urinary a stated she has observed the tubing and has observed in color. F-B stated she had sonal odor today but stated fended by the whole thing." Id be upset by the presence of thers could smell urine in the					
		o Foley catheter use and how was requested, but not					
	director of nursing of staff on resident dig	THOD OF CORRECTION: The or designee could in-service all gnity and respect. The director nee could perform random r compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		[` '			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		00261	B. WING		12/0	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
0T TUE	2505 110115	8000 BAS	S LAKE RO	AD		
STIHER	RESE HOME	NEW HOF	PE, MN 5542	8		
(X4) I D				PROVIDER'S PLAN OF CORRECT	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETE DATE
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			1/15/19
	Subd. 10. Participation in planning treatment; notification of family members.					
	in the planning of the includes the opport alternatives with incomportunity to require care conferences, a family member or or both. In the event to present, a family member or conferences. (b) If a resident with unconscious or conferences or communicate, the feefforts as required either a family member to personal to be the resident of the facing family member to personal to be the resident of the facing family member to personal to be the resident of the facing family member to personal to be the resident of the facing family member to personal to the facing family member to personal to be the facing family member to personal to be the facing family member to personal to the family member to personal to the facing family member to personal to the family member to the family member to the family member to personal to the family member t	Il have the right to participate neir health care. This right unity to discuss treatment and dividual caregivers, the set and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative lent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify the net as the person designated in the resident has been lity. The facility shall allow the participate in treatment the facility knows or has reason to the resident has an effective advance that a suppose the resident has a suppose the re				
	specified in writing member included ir notifying a family m family member to p planning, the facility efforts, consistent v practice, to determine executed an advance sident's health carthis paragraph, "rea	trary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a sarticipate in treatment in must make reasonable with reasonable medical interestive relative to the redecisions. For purposes of asonable efforts" include: the personal effects of the				

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AND DIAM OF CODDECTION IN IDENTIFICATION AND DED					OATE SURVEY OMPLETED	
		00261	B. WING		C 	
_	PROVIDER OR SUPPLIER	8000 BAS	S LAKE RO			
01 11121	(202 110III2	NEW HOP	PE, MN 5542	8		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21830	resident; (2) examining the resident in the poss (3) inquiring of ar family member conwhether the resider directive and wheth physician to whom care; and (4) inquiring of the resident normally gowhether the resider directive. If a facility designated emergemember to participal accordance with this liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making reafamily members or a design examining the personand the medical recompossession of the facility a family memergency contact admission, the facil social service agency that the resident forcement agency dentifying and notification on the facility has been member or designate county social service agency dentifying and notification on the facility has been member or designate ounty social service agency dentifying and notification of the facility has been member or designate ounty social service agency that the residentifying and notification of the facility has been member or designate ounty social service agency dentifying and notification of the facility has been member or designate ounty social service agency that the residentifying and notification of the facility has been member or designate ounty social service agency that the residentifying and notification of the facility has been member or designate ounty social service agency that the residentification of the facility has been member or designate ounty social service agency that the residentification of the facility has been member or designate ounty social service agency that the residentification of the facility has been member or designate ounty social service agency that the residentification of the facility has been member or designate out the facility has been mem	e medical records of the ression of the facility; by emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for the physician to whom the poes for care, if known, at has executed an advance of notifies a family member or not contact or allows a family ate in treatment planning in the paragraph, the facility is not or damages on the grounds that the family member or or the participation of the improper or violated the	21830			

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AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \) DATE SURVEY COMPLETED	
		00261	B. WING		12/0	C 06/2018
ST THERESE HOME 8000 BAS			DRESS, CITY, S SS LAKE RO PE, MN 5542	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	service agency or lot that assists a facility subdivision is not lia damages on the grothe family member	ocal law enforcement agency in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper	21830			
	by: Based on interview facility failed to acco	and document review, the ommodate bathing f 4 residents (R64) reviewed		Completed.		
	disease, and depre	luded ulcerative colitis, liver ssion. A quarterly Minimum ted 10/3/18, indicated R64's t.				
	able to choose how only get one showe	p.m. when asked if R64 was often he bathed, R64 stated I r on Wednesday. R64 stated sked for more showers and more.				
		ed 9/25/18, indicated R64 er a week and needed				
	nursing assistant (N have to request and they can receive an stated the bath or s	on 12/5/18, at 9:20 a.m. with NA)-B stated the residents other bath or shower before other bath or shower. NA-B howers are listed on the care Guide. NA-B stated no				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, a solesine.		c	
		00261	B. WING			6/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST THER	RESE HOME		S LAKE ROA PE, MN 5542			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 36	21830			
	resident has two ba	iths or showers on hall two.				
	NA-A stated if a res shower I would tell schedule it. NA-As	on 12/5/18, at 9:33 a.m. with sident asks for another bath or the nurse and they would stated residents would have to h or shower they are not cally.				
	During an interview on 12/5/18, at 1:31 p.m. with registered nurse (RN)-G stated the R64 had not requested another bath or shower. RN-G stated R64 would have to request another bath or shower to receive another bath or shower.					
	RN-F stated resided bath or shower a week	on 12/5/18, at 1:27 p.m. with onts could have more than one eek they have to request it. ask regularly if the residents ths or showers.				
	A policy was reques showers none was	sted for scheduling baths or provided.				
	Social Service and/ develop /revise poli educate all facility s DON and/or design interviews to ensure	THOD OF CORRECTION: for their designee could cies for resident choices and staff on those policies. The ee could conduct resident e resident choices are being then aduit to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

6899

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