DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U9RL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00261

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245518**

2.STATE VENDOR OR MEDICAID NO.
(L2) **712242000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST THERESE HOME**
(L4) **8000 BASS LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55428**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/29/19** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **258** (L18)
13.Total Certified Beds **258** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	258			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor — 01/31/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 01/31/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/11/2019
(L33)

DETERMINATION APPROVAL

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

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

DEPARTMENT OF HEALTH

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: U9RL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00261

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(L3) **ST THERESE HOME**
(L4) **8000 BASS LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55428**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/06/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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FISCAL YEAR ENDING DATE: (L35)
06/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	258			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Lisa Ciesinski, HFE NE II — 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 01/11/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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____ 2. Facility is not Eligible
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02/01/1988
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/3/18 through 12/6/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 12/3/18 through 12/6/18 and complaint investigations were also completed at the time of the standard survey. Investigations of complaints H5518082, H5518084, and H5518085 were found to be substantiated at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		1/15/19

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

Electronically Signed | 01/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were	F 550	1) Resident R705 is no longer an active resident at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 provided care in a dignified manner, and free from personal odor for 2 of 5 residents (R705 and R141) who used catheters and were reviewed for urinary incontinence. Findings include: R705's admission record indicated, R705 was recently admitted to this facility with diagnosis that included overactive bladder, malignant neoplasm of prostate, Parkinson's disease, major depressive disorder and hypertension. On 12/6/18 at 8:29 a.m., R705 was observed sitting in wheelchair eating breakfast with an uncovered urinary drainage bag with condom hooked to it hanging on the left end of the recliner chair. R705's door was observed to be wide open, as staff and visitors passed by. There was a personal aide (PA) sitting in the room at the time. The urinary drainage bag was observed to contain approximately 200 milliliters of urine. R705 verbalized that drainage bag with urine hanging on the recliner was bothersome. The PA indicated, facility staff get resident ready around 7:30 a.m., but did not empty nor clean the drainage bag. On 12/6/18 observations were conducted between 8:40 a.m. and 9:08 a.m., R705 was still observed sitting in wheelchair with an uncovered urinary drainage bag with condom hooked to it hanging on the left end of the recliner chair. R705's door was observed to be wide open, as staff (NA-D, NA-E, RN-I), residents and visitors passed by. The urinary drainage bag was observed to contain approximately 200 milliliters of urine. At 9:07 a.m., NA-D went to R705's room and transferred R705 from the wheel chair to the	F 550	2) Staff will provide care in a dignified manner. 3) Staff will be re-educated on the importance of covering up a urinary drainage bag so that it is not observed by others and providing Foley catheter hygiene care to prevent odor. 4) Weekly audits will be completed by observation of cares and/or resident interviews to ensure residents with urinary catheters are free from odor and bags are covered. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST THERESE HOME	8000 BASS LAKE ROAD NEW HOPE, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

recliner chair but did not remove, empty and clean the drainage bag that was hanging on the left side of the recliner chair. At 9:15 a.m., PA indicated, she reminded NA-D about emptying and cleaning the drainage bag but NA-D did not empty or clean the drainage bag with urine. At 9:16 a.m., R705 expressed dislike of drainage bag with urine hanging on the recliner chair.

On 12/6/18 observations were conducted between 9:16 a.m. and 10:35 a.m., R705 was still observed sitting in recliner chair with an uncovered urinary drainage bag with condom 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 4	F 550		

(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 may increase his risk for recurrence for urinary tract infections. R141 was also identified as incontinent of bowel and an incontinence brief was used. The care plan directed staff to to assist with catheter cares every shift and as needed. The care plan directed staff to manage catheter and update the the medical doctor (MD) or nurse practitioner (NP) as needed.

On 12/06/18, at 8:37 a.m. R141 was observed in his room, in bed with his eyes closed. R141's head of the bed was elevated to approximately a 45 degree angle. A smell of urine was pronounced upon entering the resident room. R141's urinary catheter bed bag was observed covered and hanging on the bed frame.

On 12/06/18, at 11:25 a.m. R141 was observed in his room resting under the covers on his bed. R141's eyes were closed. Urinary catheter tubing was observed to attach to bed bag which was connected to the bed and was covered. A more pronounced urinary odor was noted at this time.

On 12/06/18, at 11:51 a.m. registered nurse (RN)-L stated she could smell a urinary odor. RN-E joined surveyor and RN-L in the room and

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F 550	Continued From page 5	F 550		

noted the urinary odor. RN-E thought it may be coming from the black cloth bag covering the catheter bag. RN-L stated there could be bypassing of the catheter (Leaking around the catheter) which was indicative of the need to change the catheter. RN-L proceeded with provision of care for R141. RN-L stated there should not be an odor as it was a closed system. RN-L also stated the odor could indicate a sign of an infection or dehydration. RN-L stated when bypassing was noted this should be reported to the nurse as the catheter was not functioning properly. RN-L stated she had not been informed of the catheter bypassing. RN-L also commented that being wet was uncomfortable and could cause skin breakdown, as well as the odor being noticeable to others, adding no one wants to stay in the room with the smells.

On 12/06/18 at 12:05 p.m. nursing assistant (NA)-H stated she had provided R141 with personal hygiene this morning. NA-H stated the odor of urine improved with provision of personal hygiene but was still noticeable. NA-H stated she had informed RN-L of the urinary odor and the bypassing of the catheter.

On 12/06/18, at 12:59 p.m. family member (F)-B stated R141 has had his indwelling catheter for over six months and has experienced urinary tract infections. F-B stated she has observed urinary sediment in the tubing and has observed the urine to be dark in color. F-B stated she had not observed a personal odor today but stated R141 would be "offended by the whole thing." FM-A stated "I would be upset by the presence of a personal odor if others could smell urine in the room."

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F 550	Continued From page 6 The policy related to Foley catheter use and how to maintain dignity was requested, but not provided.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate bathing	F 561	1) Resident R64 interviewed to determine bathing preferences. Care plan reviewed	1/15/19

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F 561	Continued From page 7 preferences for 1 of 4 residents (R64) reviewed for choices. Findings include: R64's diagnosis included ulcerative colitis, liver disease, and depression. A quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R64's cognition was intact. On 12/3/18, at 3:53 p.m. when asked if R64 was able to choose how often he bathed, R64 stated I only get one shower on Wednesday. R64 stated that R64 had not asked for more showers and was not offered any more. R64's care plan dated 9/25/18, indicated R64 received one shower a week and needed supervision. During an interview on 12/5/18, at 9:20 a.m. with nursing assistant (NA)-B stated the residents have to request another bath or shower before they can receive another bath or shower. NA-B stated the bath or showers are listed on the Nursing Assistant Care Guide. NA-B stated no resident has two baths or showers on hall two. During an interview on 12/5/18, at 9:33 a.m. with NA-A stated if a resident asks for another bath or shower I would tell the nurse and they would schedule it. NA-A stated residents would have to ask for another bath or shower they are not schedule automatically. 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	F 561	and updated. 2) Staff will offer residents the opportunity to make choices regarding their bathing preferences. 3) Nursing staff will be re-educated on residents rights to make choices in regards to their cares and activities. 4) Residents will be offered the choice for their bathing preferences. 5) Bathing preferences will be discussed with residents or others involved in residents' care upon admission and at the quarterly care conferences. 6) Weekly audits will be completed by interviewing residents or others involved in residents' care (family/friends, etc.), if the resident is unable to speak for themselves. This will ensure residents are being offered and accommodated their bathing preference. 7) DON and/or designee is responsible for monitoring compliance. 8) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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F 561	Continued From page 8 shower to receive another bath or shower. During an interview on 12/5/18, at 1:27 p.m. with RN-F stated residents could have more than one bath or shower a week they have to request it. RN-F stated we not ask regularly if the residents would like more baths or showers. A policy was requested for scheduling baths or showers none was provided.	F 561		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		1/15/19

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F 655	Continued From page 9 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure a baseline care plan was developed within 48 hours of admission and failed to provide a written care plan summary to the resident and/or representative for 1 of 3 residents (R43) recently admitted to the facility. Findings include: R43's quarterly Minimum Data Sets (MDS) dated 9/24/18 indicates R43 had a diagnosis of congested heart failure (CHF), hypertension (HTN) elevated blood pressure, dysfunction of bladder, and dementia. The MDS also indicated R43 was totally dependent on staff for all of his activities of daily living (ADL's) and was unable to walk or transfer. R43's Resident Face Sheet indicates R43 was admitted with primary diagnosis dementia and	F 655	1) Resident R43 baseline care plan was completed upon admission. Resident and POA offered and provided with a written 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 resident and/or representative. 3) Nursing staff will be re-educated on the completion of the 48 hour baseline care plan and ensuring residents and/or representatives are offered and provided with a written care plan summary. 4) Weekly audits will be completed on all newly admitted residents to ensure residents have completed baseline 48 hour care plans and that the resident and/or representative have been offered a written care plan summary.	

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F 655	Continued From page 10 heart failure. R43's physician orders dated 10/24/18, indicates R43 required multiple medications including but not limited to : Coumadin (a blood thinner), 4 milligrams (mg) every Sunday, Tuesday, Wednesday, Thursday, Saturday and 4mg on Monday, Friday, lasix (diuretic medication) 20mg a day, Metoprolol (CHF medication) 25mg a day, Losartan (HTN medication) 25mg a day, Clopidogrel (cerebral vascular accident medication) 75mg a day and Haldol (antipsychotic medication to decrease excitement in the brain for dementia), along with laboratory orders, dietary orders, dressing changes and monitoring of other health care needs. R34's medical record lacked evidence of an initial 48 hour care plan to direct staff how to care for all R43's medical needs. R43's record also lacked evidence R34 or representative had been given a written care plan summary of cares being provided for R43. On 12/6/18, at 2:32 p.m. the director of nurses (DON) stated she reviewed R43's chart for initial 48 hour care plan or documentation to show R43 or his representative received written information and none was found. DON stated that on 11/19/18 the facility realized some of their residents did not have 48 hour care plans and residents or their representatives did not receive written information of their care. A policy related to base line care plans was requested and none was provided.	F 655	5) All current residents were reviewed to ensure 48 hour baseline care plans were completed and that the resident/representative was provided with the written care plan summary. 6) DON and/or designee is responsible for monitoring compliance. 7) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		1/15/19

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F 677	Continued From page 11 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide routine personal grooming for 2 of 4 residents (R151, R141) reviewed for activities of daily living (ADL's) and who were dependent on staff for their care. Findings include: R151's diagnosis included diabetes, chronic kidney disease, and dementia. R151's quarterly Minimum Data Set (MDS) dated 11/18/18, indicated R151 was cognitively impaired. R151's MDS indicated R151 needed extensive assistance from staff with personal hygiene. R151's care plan dated 11/19/18, indicated R151 needs extensive assistance from one staff for grooming and hygiene needs. During an observation on 12/4/18, at 9:37 a.m. R151 had approximately 15 white chin hairs 1/4 to 1/2 inch in length. R151 stated it bothered R151 to have chin hairs. During subsequent observation on 12/4/18, at 3:36 p.m. and 12/5/18, at 7:09 a.m. R151 continued to have 1/4 to 1/2 inch long white chin hairs. During an observation on 12/5/18, at 7:46 a.m.	F 677	1) Both residents R141 and R151 were provided personal grooming. R141 is no longer an active resident. 2) Staff will offer and provide routine personal grooming to all residents who are dependent upon staff for their care. 3) Nursing staff will be re-educated that each resident who is unable to carry out activities of daily living will receive the necessary services to maintain grooming and all personal cares. 4) Weekly audits will be completed to ensure residents are being provided routine grooming and personal hygiene. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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F 677	Continued From page 12	F 677		

nursing assistant (NA)-A and NA-C where assisting R151 with morning cares. NA-A brought R151 to the sink in the room and assisted with brushing R151's teeth. NA-A combed R151's hair, took the hair out of the comb and threw it in the garbage and then took the disposable razor and threw it in the garbage. R151 chin hairs were not removed and NA-A took R151 to the dining room.

During an interview on 12/5/18, at 8:33 a.m. NA-C stated we should shave the residents who want to be shaved, even the women. NA-C stated we would use a disposable razor for the women.

During an interview on 12/6/18, at 8:23 a.m. NA-A stated female residents should be shaved if they have chin hairs. NA-A confirmed R151 had not had the chin hairs removed prior to breakfast.

During an interview on 12/6/18, at 9:28 a.m. licensed practical nurse (LPN)-A stated with morning cares the expectation of staff was to shave the residents who were in need of shaving. LPN-A stated R151 does allow the staff to shave R151.

When interviewed on 12/6/18, at 1:32 p.m. the director of nursing (DON) stated if female residents want chin hairs cleaned up then we should be doing that for them. The DON stated we should have offered R151 to have the chin hairs cleaned up.

A facility policy was requested, however none was provided regarding personal cares.
R141's significant change Minimum Data Set (MDS) dated 11/16/18 indicated R141 had

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F 677	Continued From page 13	F 677		

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 may increase his risk for recurrence for urinary tract infections. R141 was also identified as incontinent of bowel and an incontinence brief was used. R141's care plan also indicated R141 was at risk for developing a pressure ulcer related to bowel incontinence, decreased mobility related to right hip dislocation, lack of understanding/compliance with turning and repositioning needs, and history of pressure ulcers and had a blood blister on his left great toe. The care plan directed staff to ensure R141 has his blue Prevalon boots on while in bed.

On 12/06/18, at 8:37 a.m. R141 was observed in his room, in bed with his eyes closed. R141's head of the bed was elevated to approximately a 45 degree angle. A smell of urine was pronounced upon entering the resident room. R141's urinary catheter bed bag was observed covered and hanging on the bed frame. R141's foam boots were in the chair next to the bed.

On 12/06/18, at 11:25 a.m. R141 was observed in his room resting under the covers on his bed. R141's eyes were closed. Urinary catheter tubing was observed to attach to bed bag which was connected to the bed and was covered. A more pronounced urinary odor was noted at this time.

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F 677	Continued From page 14	F 677		

R141's foam boots remained on the chair.

On 12/06/18, at 11:51 a.m. registered nurse (RN)-L stated she could smell a urinary odor. RN-E joined surveyor and RN-L in the room and noted the urinary odor. RN-L stated there could be bypassing of the catheter (Leaking around the catheter) which was indicative of the need to change the catheter. RN-L proceeded with provision of care for R141. RN-L stated there should not be an odor as it was a closed system. RN-L also stated the odor could indicate the signs of an infection or dehydration. RN-L stated when bypassing was noted this should be reported to the nurse as the catheter was not functioning properly. RN-L stated she had not been informed of the catheter bypassing. RN-L also commented being wet was uncomfortable and could cause skin breakdown, as well as the odor being noticeable to others, adding no one wants to stay in the room with the smells. RN-L stated R141's foam boots should be in place on both feet when resident is in bed due to the potential for skin breakdown.

On 12/06/18 at 12:05 p.m. nursing assistant (NA)-H stated she had provided R141 with personal hygiene this morning. NA-H stated the odor of urine improved with provision of personal hygiene but was still noticeable. NA-H stated she had informed RN-L of the urinary odor and the bypassing of the catheter. NA-H had stated the foam boots were not in place this morning and she did not wish to waken R141 to inquire if he wished to wear his foam boots, although stated she had performed personal hygiene and pericare for incontinence.

On 12/06/18, at 12:59 p.m. family member

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F 677	Continued From page 15 (FM)-B stated R141 has had his indwelling catheter for over six months and has experienced urinary tract infections. FM-B stated she has observed urinary sediment in the tubing and has observed the urine to be dark in color. FM-B stated she had not observed a personal odor today but stated R141 would be "offended by the whole thing." FM-A stated "I would be upset by the presence of a personal odor if others could smell urine in the room." FM-B stated she had removed R141's boots last night and had failed to reapply them . FM-B stated the foam boots were in place to prevent pressure concerns. The policy related to Foley catheter use and how to maintain dignity was requested, but not provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an upright position was maintained while seated in an adaptive wheelchair for 1 of 2 residents (R116) and failed to investigate bruising for 1 of 3 residents (R703) reviewed for non-pressure	F 684	1) Resident R116's wheelchair seat depth was lengthened, wheelchair armrest was elevated, OT orders received for wheelchair positioning. Resident R703 bruising of unknown cause was reported to MDH and investigation initiated and	1/15/19

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F 684	Continued From page 16 related skin concerns. Findings include: R116's quarterly Minimum Data Set (MDS) dated 10/29/18, indicated R116 had severe cognitive impairment and received extensive assistance with transfers and mobility. R116's medical diagnoses included: Alzheimer's, dementia, chronic pain, a history of falling, and a closed fracture with routine healing. R116's care plan dated 5/24/18, indicated R116 had decreased mobility related to an impaired balance, impaired cognition, dementia (Alzheimer's type), impaired vision, chronic pain, a history of falls, and a right femur fracture. The care plan directed staff to use a high back tilt recline (HBTR) chair for mobility. On 12/04/18, at 10:58 a.m. R116 was observed seated in the day room in an adaptive wheelchair with a head and neck support cushion in place. R116 was observed with her back resting on the back of the chair and curled over to the left side of the chair. The head/neck support was not providing support to R116. At 11:15 a.m. R116 was present at an activity in the day room. R116 was observed leaning to the left side in the Broda chair during music program. R116's hips were positioned to the right side of the chair with knees pointing to the left side and her feet resting on the footrest. At this time, R116's head was below the head support with no support present. R116's outer aspect of her left upper body was observed extending outside of the chair support when observed from behind the wheelchair. On 12/04/18, at 3:46 p.m. R116 was observed	F 684	completed. 2) Staff will provide quality care to all residents, which includes ensuring that residents are able to maintain an upright position while in his or her wheelchair and to report any bruises of unknown origin to supervisor and administrator/designee. 3) Staff will be re-educated that each resident must receive cares to ensure that he or she is positioned correctly when up in the wheelchair and protocol to follow when bruise of unknown origin is noted. 4) Weekly audits will be completed by observation of residents to ensure that they are positioned correctly and able to maintain an upright position when in a wheelchair/chair. Nurse managers will review all nurse documentation for their units to ensure that any bruises of unknown origin were reported to supervisor and administrator/designee. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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seated in her wheelchair. R116 is seated in an upright position with her head leaning to the left hand side of the chair back. Although the head/neck cushion is in place,it provides no support to the resident. R116 was able to shift herself towards the center of the chair with verbal cues, however, her head remained unsupported by the head/neck support.

On 12/05/18, at 10:09 a.m. R116 was observed seated in her wheelchair in the dayroom. R116 was sitting with her eyes closed, with her head and upper body observed leaning towards the left side of the chair outside the support of the head/neck cushion. At 10:54 a.m. R116 was observed seated in her wheelchair with hips positioned back and to the left, and her knees twisted to the right with her feet on the footrest.

On 12/05/18, at 11:02 a.m. trained medical assistant (TMA)-A stated R116's head was not lining up with head/neck support. TMA-A stated R116's leaning to the side would increase pressure for the side she was leaning.

On 12/05/18, at 11:10 a.m. registered nurse (RN)-E stated the wheelchair seat should be lengthened. RN-E removed the head/neck support as this was not supportive of resident's upper body. RN-E also elevated the arm rest on the left side, and placed R116's left arm on the arm rest.

On 12/06/18, at 11:20 a.m. R116 was observed in the day room seated in her wheel chair with her hips center and positioned to the back of the chair, with her upper body leaning to the left. R116's left hand is observed resting on her lap.

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A facility policy was requested for the resident referral process to therapies for wheelchair positioning but was not provided.

R703's admission record indicated, R703 was admitted to this facility on 11/28/18 with diagnoses including multiple fractures of ribs-left side, diabetes type II, pain and history of falling. In addition, the electronic treatment record indicated R703's weekly skin check was done on 12/3/18 but did not address the bruise identified on the right side of the abdomen.

R703's care plan undated, identified R703 had a potential for an activities of daily living deficit and needed assistance with care and to restore maximal function related to diagnosis fall rib fracture. In addition, R703's revise care plan dated 12/4/18, directed staff to "Monitor bruise to RLQ Abd qd (right lower quadrant abdomen every day), until resolved. Report > (increase) bruising, presence of swelling, redness, or pain to MD/NP (medical doctor/nurse practitioner)".

On 12/3/18 at 3:48 p.m., R703 was observed sitting in wheelchair in his room during an interview, R703 mentioned, he had bruise and lifted his shirt up. Bruise was an egg size dark purple bruise on the right side of abdomen. When asked how he got it, R703 indicated, he does not know and denied pain on the site.

R703's progress note dated 12/2/18, at 1:17 p.m. read, " ... Dark bruising noted to lower left side of abdomen, mid lower back ..." However, the medical record lacked documentation of the bruising on the right side of R703's abdomen.

R703's progress note dated 12/3/18, at 10:15

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p.m. read, " ... Dark bruising noted to lower left abdomen to mid lower back. Denies pain ..." However, the medical record lacked documentation of the bruising on the right side of R703's abdomen.

R703's progress note dated 12/4/18 at 1:43 p.m., read, "RLQ bruise; measuring 4.5 cm (centimeter) x 7.0 cm, (3) parallel horizontal lines, superficial abrasion to Apex of the bruise, and various shade of bruising (darker distally, lighter proximal, lighter between the horizontal lines). The injury is consistent w/ the position & location of the transfer belt. Patient is an assist of 1 w/ (with) transfers & ambulation. The location of the bruise is not located in a suspicious area of the body. No pain. The patient is A&O (alert and oriented) x 3. Patient does not recall how the bruise occurred. Patient did not realized a bruise was present. Patient stated that he bruises easily. No recent fall, at TCU (transition care unit). Last know fall was at home. Recently started a ambulation program and currently taking ASA (aspirin). Patient states no one caused any harm to him. Patient stated that he feels safe. DON (director of nursing) updated. NP updated. Family updated."

R703's progress note dated 12/4/18 at 1:50 p.m., read, "RLQ Abd: Reported & reviewed bruise with family member [(F)-A]. [F-A] agreed with the conclusion that the bruise is related to the transfer belt, during transfers and ambulation. [F-A] indicated that the patient bruises easily. [F-A] indicated that in the near future, she plans to discuss the use & risks/benefits of ASA with the patient .... [F-A] thanked writer for the call. [F-A] had no concerns and no further questions."

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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 administrator had been updated. Facility report incident was done. Staff reeducation and audits were initiated. Will meet with the staff that documented the bruising in the progress note for

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F 684	Continued From page 21 further reeducation. In addition, RN-J indicated, staff were trained to report any new skin concerns to the nurse manager or supervisor or DON and document accurately with description in the progress note. On 12/5/18 at 11:07 a.m., physical therapist (PT)-A mentioned, she evaluated resident on 11/29/18 and did not notice any bruise on resident's abdomen and has not worked with R703 since then. On 12/5/18 at 11:17 a.m., the occupation therapy (OT)-A indicated, she had worked with R703 on 12/3/18 on toileting and R703 required contact guarding to the toilet and required moderate assistant with dressing. OT-A stated she notice some bruising, but it was more to the side then on the back. An undated facility policy and procedure titled SKIN INTEGRITY PROTOCOL FOR NURSES, directed staff, "1. Update nurse manager and /or House Supervisor upon discovery of all new skin alterations which includes bruises, pressure ulcers, diabetic ulcers, vascular ulcers, skin tears, blisters, lacerations and surgical wounds. 2. Notify MD/NP to obtain new wound treatment orders. 3. Notify the resident/legal representative of the new wound/skin alterations. 4. Complete skin alteration progress note in PCC [point click care] and complete a risk management UDA (pressure ulcers/skin tears) ..."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		1/15/19

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F 686	Continued From page 22 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Prevalon boots (pressure relieving foam boots) were used consistently to reduce pressure for 1 of 3 residents (R141) reviewed for pressure ulcers. Findings include: 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: cancer, anemia, heart failure, peripheral vascular disease (A blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.) diabetes, right hip dislocation, arthritis, and pain. R141's care plan revised on 12/3/18, indicated R141 was at risk for developing a pressure ulcer related to bowel incontinence, decreased mobility related to right hip dislocation, lack of	F 686	1) Resident R141 Prevalon boots were placed on resident. Education/coaching completed with NAR. 2) Staff will ensure that a resident receives care to prevent pressure ulcers and that a resident does not develop pressure ulcers unless it is unavoidable. 3) Nursing staff will be re-educated to follow all orders and interventions in place for residents with treatments/services to prevent pressure ulcers. 4) Weekly audits will be completed by observation of residents receiving treatment/services for the prevention of pressure ulcers to ensure that professional standards of practice are being followed. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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understanding/compliance with turning and repositioning needs, a history of pressure ulcers, and a blood blister on left great toe. The care plan directed staff to ensure R141 has his blue Prevalon boots on while in bed.

On 12/06/18, at 8:37 a.m. R141 was observed in bed lying on his back with a footboard at the foot of the bed, supporting blankets off of feet, however, his Prevalon foam boots were not in place on his feet, boots were sitting on his wheelchair.

On 12/06/18, at 11:25 a.m. R141 remained in bed at this time, in a back lying position. R141's Prevalon foam boots continued to be on his wheelchair.

On 12/06/18, at 11:51 a.m. A registered nurse (RN)-L stated R141 was to have his foam boots on while in bed as the foam boots were worn to prevent pressure ulcers, primarily in the heels/ankles. RN-E stated the use of the foam boots were recommended to be used as outlined in the care plan.

On 12/06/18, at 12:05 p.m. nursing assistant (NA)-H stated R141's boots were not on at the beginning of her shift. NA-H stated although she had assisted R41 with change of incontinence brief, she did not wish to fully awaken resident to ask if he would wear his boots.

On 12/06/18, at 12:09 p.m. RN-L stated R141's boots were to be in place at all times. RN-L stated if personal cares were completed, R141's foam boots should have been applied at that time.

On 12/06/18, at 12:59 p.m. family member

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F 686	Continued From page 24 (FM)-B stated R141 was to wear his boots at all times. FM-B stated she had removed his boots last night to give him some time to move his feet and had not reapplied them prior to leaving. A policy was requested for proper use and application of pressure relieving devices was requested but was not received.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions listed on the care plan to prevent spilling of hot beverages for 1 of 5 residents (R109) reviewed for accidents. Findings include: R109's quarterly Minimum Data Set (MDS) dated 10/26/18, identified R109 had severe cognitive impairment with diagnosis of dementia and muscle weakness. The MDS further identified R109 eats and drinks with supervision. R109's care plan revised on 11/5/18, identified R109 can feed self-following set-up, with supervision at meals. R109's care plan indicated	F 689	1) Cover placed to cup of resident R109 . Care plan reviewed and current. 2) Staff will ensure that the resident's environment remains as free of accidents/hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. A list was completed with all residents utilizing adaptive equipment and this was provided to department heads to share with their staff members. 2) Staff will be re-educated that interventions listed on the care plan to prevent accidents must be followed. 3) Weekly audits will be completed by observation of residents utilizing assistive	1/15/19

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F 689	Continued From page 25 R109 utilized a spouted mug with cover when served hot liquids R109's progress note dated 11/05/18, indicated during weekly shower a fluid filled blister was noted on mid-thigh. The progress note indicated that R109 reported she got burned a couple days ago, R109 is right handed and likes to drink hot coffee. Progress note indicated care plan revised for spouted cup with lid for hot beverages. During observation on 12/04/18, at 3:23 p.m. R109 was sitting at dining table in her wheelchair eating a Christmas cookie, R109 dropped her regular uncovered coffee cup, spilling coffee on 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	F 689	devices to ensure that the interventions listed on the care plan are being followed. 4) DON and/or designee is responsible for monitoring compliance. 5) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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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 practitioner were updated regarding the spill.

On 12/06/18, at 8:54 am R109's skin was assessed by writer and RN-A and RN-D, no redness or blisters were noted.

When interviewed on 12/06/18, at 8:54 am with TC-B stated the therapeutic recreation staff just recently started to print a new list before each activity from point click care which not only lists diets, but special adaptive equipment if needed.

When interviewed on 12/06/18, at 9:20 am RN-A stated the spouted cups with the cover come from the kitchen, RN-A went on to say it is also on meal ticket. At coffee time, the TC prints a daily diet list that has that information on it. RN-A stated typically the cups with lids should be available on the unit in the kitchenette.

When interviewed on 12/06/18, at 10:08 am nursing assistant (NA)-F stated she would know that R-109 needed a spouted cup with a lid because it is on the meal ticket from the kitchen

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F 689	Continued From page 27 and in R-109's care plan. A policy was requested for following care plans, no policy received.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		1/15/19

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F 690	Continued From page 28 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that an indwelling catheter was changed according to physician orders for 1 of 3 residents (R99) reviewed with an indwelling Foley catheter. Findings include: R99 quarterly Minimum Data Set (MDS) dated 10/25/18, indicated R99's diagnoses included obstructive and reflux uropathy (urine cannot drain through the urinary tract), history of urinary tract infection (UTI), and retention of urine, benign prostatic hyperplasia (BPH) (enlarged prostate) and chronic kidney disease. MDS indicated R99 was cognitively intact. R99's care plan printed on 12/06/18, indicated R99 has a Foley catheter due to obstructive uropathy, BPH, urinary retention and frequency. R99 is being seen by a urologist and is at risk for retention and UTI. Last hospitalized 8/8/18 with a UTI. Review of R99's Order Summary Report dated 10/31/18, directed Foley to be changed at urologist's office every month, starting on the 25th for 28 days. R99 had a physician's order to change 16F 5 cc balloon as needed (PRN) if clogged and unable to flush. Review of R99's patient visit note from urologist dated 11/28/18, indicated if there are any significant cardiac concerns, would continue	F 690	1) Resident R99 indwelling catheter was changed. 2) Staff will ensure that all residents with Foley catheters receive the appropriate treatment/services per physician or urologist orders. 3) Nursing staff will be re-educated to ensure that all resident with indwelling catheters are changed per orders. 4) Weekly audits will be completed by observation of residents with Foley catheters to ensure that catheters are being changed per orders. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING _____ B. WING _____	C 12/06/2018

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

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F 690	Continued From page 29	F 690		

Foley drainage for now and forego the supra pubic catheter placement and continue catheter change every 4 weeks.

When interviewed on 12/05/18, at 1:00 p.m. R99 stated he had to see a special doctor for his catheter on 11/28/18, R99 went on to say the plan was to have a supra pubic catheter placed on 12/07/18, but is not able to due to concerns from his cardiologist. R99 stated he thought it had been over a month since he had his catheter changed. R99 stated he had problems with urinary tract infections and problems with his catheter getting plugged, R99 went on to say that the nursing home has had difficulty changing his catheter in the past and needed to go to the urologist every month for it to be changed.

During interview on 12/05/18, at 1:22 pm registered nurse (RN)-E stated R99's catheter should have been changed on 11/28/18 when R99 went to see the urologist. RN-E reviewed the visit note dated 11/28/18, which indicated R99 was only seen for a consult for supra pubic catheter placement. RN-E stated at that time the urologist had not spoken to the cardiologist. RN-E went on to say the surgery had been canceled for the supra pubic catheter on 11/30/18. RN-E looked at the electronic treatment administration record (ETAR) for November 2018, which indicated R99's last catheter change was on 11/02/18 at the nursing home per the PRN order. RN-E checked the appointment book to see if a urology appointment was scheduled for a catheter change, the schedule lacked a future appointment. RN-E stated an appointment should have been scheduled and it must have been missed. RN-E stated R99's ETAR indicated the catheter should

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F 690	Continued From page 30 be changed every 28 days. RN-E stated she would call the urologist office to follow up and see if monthly changes needed to be in office or if it could be done at the nursing home. During interview on 12/06/18, at 1:16 p.m. health unit coordinator (HUC)-C stated when a resident goes to an outside appointment a visit referral and an order sheet will go with. HUC-C went on to say at times they may come back with notes and recommendations on their own form. HUC-C stated the notes and recommendation are given to the nurse manager to review before she can put in any orders or schedule any appointments. A policy was requested, none received.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen tubing was changed in a timely manor for 1 of 1 residents (R195) reviewed for oxygen therapy. Findings include: R195's significant change Minimum Data Sets	F 695	1) R195 tubing was changed and nursing orders added to the EMAR for weekly tubing changes every Tuesday night shift for all residents requiring oxygen and nebulizers. 2) Staff will ensure that all residents requiring respiratory care will have cares provided consistent with professional	1/15/19

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F 695	Continued From page 31 (MDS) dated 11/ 26/18, indicated R195 has a diagnosis of anxiety, chronic obstructive pulmonary disease (COPD) requiring oxygen, congestive heart failure and (CHF), Peripheral vascular disease (PVD) and R195 was on hospice for palliative care receiving oxygen therapy. R195's physician order dated 11/15/18, indicated R195 was to have oxygen per a nasal cannula at 2-5 liters per minute as needed for respiratory comfort. R195 was observed to have between 2-3 liters of oxygen on per nasal cannula. R195's care plan dated 10/19/18, did not address R195's need for oxygen. During observation on 12/4/18, at 3:21 p.m. R195 was resting in bed in an upright position, non verbal, and had oxygen on per nasal cannula at 3 liters per minute. The tubing for oxygen was not dated. During observation on 12/5/18, at 1:05 p.m. R195's daughter and other family friends were in R195's room. R195 oxygen tubing is not dated and it was running at 2 liters per minute. During interview on 12/5/18, at 1:21 p.m. registered nurse (RN)-K stated the night shift is supposed to change oxygen tubing when it is due to be changed. RN-K stated there was no documentation in the treatment administration record (TAR) as to when the tubing had last been changed and stated no date on the current tubing in use by R195. RN-K stated best practice is that new tubing changes should be recorded in TAR, however it is not, and RN-K did not know when the tubing for R195 was last changed.	F 695	standards of practice. 3) Nursing staff will be re-educated that all residents with oxygen and nebulizer tubing must have them changed weekly and documented on the EMAR/ETAR 4) Weekly audits will be completed with residents on oxygen and nebulizers to ensure that tubing changes are being completed and documented on the EMAR/ETAR. Weekly audits completed on new admission needing respiratory care to ensure nursing orders are placed in the EMAR/ETAR and documented when completed. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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F 695	Continued From page 32 During interview on 12/5/18, after 1:21p.m. the director of nursing (DON) stated it is the facilities usual practice to document new oxygen tubing change date in the TAR. The DON stated there was not any documentation of when R195's oxygen tubing was lasted changed. The DON stated there is no policy or procedure on new oxygen tubing for residents. The manufacture of Nasal Cannula, Salter Labs, Home Oxygen Tubing Bulletin recommends replacing nasal cannula at least once every 14 days. Do not use your cannula for more than 30 days.	F 695		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		1/15/19

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F 791	Continued From page 33 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide routine dental services for 1 of 2 residents (R64) reviewed for dental services Findings include: R64's diagnosis included ulcerative colitis, liver disease, and depression. A quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R64's cognition was intact. R64's quarterly Pain Interview; Balance and ROM (range of motion); Oral/Dental Status-V2 dated 10/2/18, indicated R64 was not asked does the resident need or want a dental exam? There was	F 791	1) Resident R64 was offered dental services. Quarterly pain interview, Balance and ROM, Oral/Dental status- V2 assessment was updated with specific questions regarding if the resident wants to be seen, last time see, and if resident does not want to be seen, risks and benefits are verbalized. MDS cannot close without assessment questions being answered. The assessment is completed for all MDS except "end of PPS stay". Care conference summary assessment updated to include documentation that resident has been offered ancillary services. 2) Staff will assist resident in obtaining	

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F 791	Continued From page 34 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 12/13, indicated residents shall be offered dental services as needed.	F 791	routine and 24 hour emergency dental care. 3) Staff will be educated that all residents are eligible to receive dental services. 4) Weekly audits will be completed by resident/family interview and /or assessment completed to ensure dental care has been offered. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		1/15/19

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F 921	Continued From page 35 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure a residents wheel chair was clean and sanitary for 1 of 1 residents (R138) reviewed for environment. Findings include: R138's quarterly Minimum Data Sets (MDS) dated 11/11/18, indicated R138's diagnosis included, severely impaired cognition, hypertension (elevated blood pressure), depression and Parkinson (chronic progressive neurological disease). R138 required a wheel chair for mobility with staff to propel to all locations. R138's care plan dated 12/6/18, indicates R138 required extensive assistance with all his activities of daily living. During observation on 12/3/18, when observing R138's wheelchair, it was noted to have dried white substance and a sticky looking clear substance on the frame and covers of the wheel chair. During observation of R138's wheelchair during the dates of 12/3/18 through 12/6/18, R138 continued to have an unclean wheelchair with old dried food and dried liquid on the chair. During interview on 12/6/18, at 11:36 a.m. nurse	F 921	1) Resident R138 wheelchair was cleaned. 2) Staff will ensure that residents are provided with a safe, functional, sanitary, and comfortable environment. 3) Staff will be educated on the process of wheelchair cleaning at St. Therese New Hope SNF. 4) Weekly audits will be completed to ensure that wheelchairs are being cleaned per facility protocol. 5) DON and/or designee is responsible for monitoring compliance. 6) The QAPI committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process based on the compliance noted.	

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F 921	Continued From page 36 assistant (NA)-G stated R138's wheelchair is dirty and needs to be cleaned. During interview on 12/6/18, at 11:45 a.m. licensed practical nurse (LPN)-B stated R 138's wheelchair is dirty and needs to be cleaned. LPN-B stated nurses are supposed to wipe the wheel chair down when viably soiled. LPN-B stated nursing has a cleaning list and R138's name is on the list, however it is not initialed as having been cleaned. During record review of the Wheelchair Washing Schedule, R138's name was on the list to have wheelchair washed, however it is not initialed as done or clean. A facility policy for Cleaning and Disinfection of Resident-Care Items and Equipment dated revised 2014, indicates resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.	F 921		

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2018**

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K 000	INITIAL COMMENTS 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), 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	K 000	EPOC	

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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K 000	Continued From page 1 IS NOT REQUIRED.	K 000		

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

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K 000	Continued From page 2 surveyed as one building. The building is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 258 beds and had a census of 226 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 226 residents. Findings include: On a facility tour between the hours of 10:00 AM and 03:00 PM on December 05, 2018, it was	K 521	AA continuum Waiver is being requested for K521. Compliance with this provision will cause an unreasonable hardship in accordance with SOM 2480C because: - The cost estimated for complying HVAC system dated 4/8/2014 is 1,000000.00 Financing costs at 5% add an additional $272,768. to the project. - Under current reimbursement rates, we estimate that it takes up to 50 years to	1/15/19

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

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K 521	Continued From page 3 revealed the heating, ventilation and air conditioning systems for the first and second floor of the 1968 building are using the corridor system as part of the air distribution system as a return air plenum through the bathroom exhaust. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521	recoup the project costs. - installation and construction work of the new ventilation system would also severely impact the residents ability to move about the facility and affect their quality of life with the construction noise, dust, and obstructions. - The building design with a fixed solid corridor ceiling limits installation options because of inadequate headroom that would result in adding ductwork. The current ceiling height is 8 feet, the addition of ducts and ceiling headroom to less than 6'5". - The building is currently 50 years old and strategic planning for the organization has begun for the future renovation or replacement of this building in 2020. B) There will be no adverse effect on the building occupants saety in accordance with SOM2480B because: -St. Therese home is a 3 level type 2 building structure with interior finish ratings for flame 20 and smoke 85 on the first floor, flame 25 and smoke 45on the 2nd floor, and flame 15 and smoke 30 on the 3rd floor. - the walls, floors, ceiling and vertical openings were designed and constructed to resist the passage of smoke. -There are three smoke compartments on each floor of the facility. - Training for staff on the facility compliant fire safety plan is conducted annually. - The facility is fully sprinkled. - A fire watch procedure is implemented whenever the fire alarm or fire sprinkler system are down for maintenance, repair or upgrades. The plant operations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2018**

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

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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 review. -The fire department station is 2 miles away and has an average of 3 minute response time. -The 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 staff. -The facility is inspected annually by a deputy from the MN fire marshal office. -The staffing ratio is 1 staff per 1.3 residents in a 24 hour period.	
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing	K 541		1/15/19

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2018**

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K 541	Continued From page 5 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 use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not seal the vertical chute with the appropriate fire protective rating in accordance with the 2012 LSC NFPA 101. 9.5. This deficient practice could effect all residents in the smoke compartment. Findings include: On a facility tour between the hours of 10:00 AM and 03:00 PM on December 05, 2018, it was 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 541	The door on the 2nd floor soiled linen chute in room 241 has been replaced with a fire door assembly Classified 'UL' Class B labeled: 1-1/2 hour fire rated. See addendum 2. Checking linen chute doors for code compliance will be included in the monthly Preventative maintenance program. The Director of Plant Operations will review the Preventative Maintenance entries monthly to assure compliance.	
K 712 SS=C	Fire Drills 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	K 712		1/15/19

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	245518	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2018**

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K 712	Continued From page 6 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility did not conduct fire drills at unexpected times and varied conditions. The facility also did not verify the transmission of a fire alarm signal when fire drills were conducted. This is not in accordance with 2012 edition of NFPA 101, Life Safety Code, Section 19.7.1.4. This deficient practice could affect all 226 residents. Findings include: On a facility tour between the hours of 10:00 AM and 3:00 PM on December 05, 2018, it was revealed that The facility could not provide evidence of having completed a fire drill for the 3rd shift during the 3rd quarter of 2018. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 712	Fire drills will be held at unexpected times under varying conditions quarterly on each shift. See addendum 3. A reoccurring PM schedule will be included in the Preventative Maintenance system. The Director of Plant Operations will review the preventative maintenance entries and the hard copy report monthly for compliance.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

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.

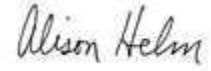
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	C 12/06/2018

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

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

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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 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 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 Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen tubing was changed in a timely manor for 1 of 1 residents (R195) reviewed for oxygen therapy, failed to ensure an upright position was maintained while seated in an adaptive wheelchair for 1 of 2 residents (R116) failed to investigate bruising for 1 of 3 residents (R703) reviewed for non-pressure related skin concerns and failed to implement interventions listed on the	2 830	Completed.	1/15/19

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2 830	Continued From page 3 care plan to prevent spilling of hot beverages for 1 of 5 residents (R109) reviewed for accidents. Findings include: R195's significant change Minimum Data Sets (MDS) dated 11/ 26/18, indicated R195 has a diagnosis of anxiety, chronic obstructive pulmonary disease (COPD) requiring oxygen, congestive heart failure and (CHF), Peripheral vascular disease (PVD) and R195 was on hospice for palliative care receiving oxygen therapy. R195's physician order dated 11/15/18, indicated R195 was to have oxygen per a nasal cannula at 2-5 liters per minute as needed for respiratory comfort. R195 was observed to have between 2-3 liters of oxygen on per nasal cannula. R195's care plan dated 10/19/18, did not address R195's need for oxygen. During observation on 12/4/18, at 3:21 p.m. R195 was resting in bed in an upright position, non verbal, and had oxygen on per nasal cannula at 3 liters per minute. The tubing for oxygen was not dated. During observation on 12/5/18, at 1:05 p.m. R195's daughter and other family friends were in R195's room. R195 oxygen tubing is not dated and it was running at 2 liters per minute. During interview on 12/5/18, at 1:21 p.m. registered nurse (RN)-K stated the night shift is supposed to change oxygen tubing when it is due to be changed. RN-K stated there was no documentation in the treatment administration record (TAR) as to when the tubing had last been	2 830		

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2 830	Continued From page 4	2 830		

changed and stated no date on the current tubing in use by R195. RN-K stated best practice is that new tubing changes should be recorded in TAR, however it is not, and RN-K did not know when the tubing for R195 was last changed.

During interview on 12/5/18, after 1:21p.m. the director of nursing (DON) stated it is the facilities usual practice to document new oxygen tubing change date in the TAR. The DON stated there was not any documentation of when R195's oxygen tubing was lasted changed. The DON stated there is no policy or procedure on new oxygen tubing for residents.

The manufacture of Nasal Cannula, Salter Labs, Home Oxygen Tubing Bulletin recommends replacing nasal cannula at least once every 14 days. Do not use your cannula for more than 30 days.

R116's quarterly Minimum Data Set (MDS) dated 10/29/18, indicated R116 had severe cognitive impairment and received extensive assistance with transfers and mobility. R116's medical diagnoses included: Alzheimer's, dementia, chronic pain, a history of falling, and a closed fracture with routine healing.

R116's care plan dated 5/24/18, indicated R116 had decreased mobility related to an impaired balance, impaired cognition, dementia (Alzheimer's type), impaired vision, chronic pain, a history of falls, and a right femur fracture. The care plan directed staff to use a high back tilt recline (HBTR) chair for mobility.

On 12/04/18, at 10:58 a.m. R116 was observed seated in the day room in an adaptive wheelchair

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2 830	Continued From page 5	2 830		

with a head and neck support cushion in place. R116 was observed with her back resting on the back of the chair and curled over to the left side of the chair. The head/neck support was not providing support to R116. At 11:15 a.m. R116 was present at an activity in the day room. R116 was observed leaning to the left side in the Broda chair during music program. R116's hips were positioned to the right side of the chair with knees pointing to the left side and her feet resting on the footrest. At this time, R116's head was below the head support with no support present. R116's outer aspect of her left upper body was observed extending outside of the chair support when observed from behind the wheelchair.

On 12/04/18, at 3:46 p.m. R116 was observed seated in her wheelchair. R116 is seated in an upright position with her head leaning to the left hand side of the chair back. Although the head/neck cushion is in place,it provides no support to the resident. R116 was able to shift herself towards the center of the chair with verbal cues, however, her head remained unsupported by the head/neck support.

On 12/05/18, at 10:09 a.m. R116 was observed seated in her wheelchair in the dayroom. R116 was sitting with her eyes closed, with her head and upper body observed leaning towards the left side of the chair outside the support of the head/neck cushion. At 10:54 a.m. R116 was observed seated in her wheelchair with hips positioned back and to the left, and her knees twisted to the right with her feet on the footrest.

On 12/05/18, at 11:02 a.m. trained medical assistant (TMA)-A stated R116's head was not lining up with head/neck support. TMA-A stated R116's leaning to the side would increase

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2 830	Continued From page 6 pressure for the side she was leaning. On 12/05/18, at 11:10 a.m. registered nurse (RN)-E stated the wheelchair seat should be lengthened. RN-E removed the head/neck support as this was not supportive of resident's upper body. RN-E also elevated the arm rest on the left side, and placed R116's left arm on the arm rest. On 12/06/18, at 11:20 a.m. R116 was observed in the day room seated in her wheel chair with her hips center and positioned to the back of the chair, with her upper body leaning to the left. R116's left hand is observed resting on her lap. A facility policy was requested for the resident referral process to therapies for wheelchair positioning but was not provided. R703's admission record indicated, R703 was admitted to this facility on 11/28/18 with diagnoses including multiple fractures of ribs-left side, diabetes type II, pain and history of falling. In addition, the electronic treatment record indicated R703's weekly skin check was done on 12/3/18 but did not address the bruise identified on the right side of the abdomen. R703's care plan undated, identified R703 had a potential for an activities of daily living deficit and needed assistance with care and to restore maximal function related to diagnosis fall rib fracture. In addition, R703's revise care plan dated 12/4/18, directed staff to "Monitor bruise to RLQ Abd qd (right lower quadrant abdomen every day), until resolved. Report > (increase) bruising, presence of swelling, redness, or pain to MD/NP (medical doctor/nurse practitioner)".	2 830		

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2 830	Continued From page 7 On 12/3/18 at 3:48 p.m., R703 was observed sitting in wheelchair in his room during an interview, R703 mentioned, he had bruise and lifted his shirt up. Bruise was an egg size dark purple bruise on the right side of abdomen. When asked how he got it, R703 indicated, he does not know and denied pain on the site. R703's progress note dated 12/2/18, at 1:17 p.m. read, " ... Dark bruising noted to lower left side of abdomen, mid lower back ..." However, the medical record lacked documentation of the bruising on the right side of R703's abdomen. R703's progress note dated 12/3/18, at 10:15 p.m. read, " ... Dark bruising noted to lower left abdomen to mid lower back. Denies pain ..." However, the medical record lacked documentation of the bruising on the right side of R703's abdomen. R703's progress note dated 12/4/18 at 1:43 p.m., read, "RLQ bruise; measuring 4.5 cm (centimeter) x 7.0 cm, (3) parallel horizontal lines, superficial abrasion to Apex of the bruise, and various shade of bruising (darker distally, lighter proximal, lighter between the horizontal lines). The injury is consistent w/ the position & location of the transfer belt. Patient is an assist of 1 w/ (with) transfers & ambulation. The location of the bruise is not located in a suspicious area of the body. No pain. The patient is A&O (alert and oriented) x 3. Patient does not recall how the bruise occurred. Patient did not realized a bruise was present. Patient stated that he bruises easily. No recent fall, at TCU (transition care unit). Last know fall was at home. Recently started a ambulation program and currently taking ASA (aspirin). Patient states no one caused any harm	2 830		

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2 830	Continued From page 8 to him. Patient stated that he feels safe. DON (director of nursing) updated. NP updated. Family updated." R703's progress note dated 12/4/18 at 1:50 p.m., read, "RLQ Abd: Reported & reviewed bruise with family member [(F)-A]. [F-A] agreed with the conclusion that the bruise is related to the transfer belt, during transfers and ambulation. [F-A] indicated that the patient bruises easily. [F-A] indicated that in the near future, she plans to discuss the use & risks/benefits of ASA with the patient .... [F-A] thanked writer for the call. [F-A] had no concerns and no further questions." 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	2 830		

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2 830	Continued From page 9	2 830		

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 administrator had been updated. Facility report incident was done. Staff reeducation and audits were initiated. Will meet with the staff that documented the bruising in the progress note for further reeducation. In addition, RN-J indicated, staff were trained to report any new skin concerns to the nurse manager or supervisor or DON and document accurately with description in the progress note.

On 12/5/18 at 11:07 a.m., physical therapist (PT)-A mentioned, she evaluated resident on 11/29/18 and did not notice any bruise on resident's abdomen and has not worked with R703 since then.

On 12/5/18 at 11:17 a.m., the occupation therapy (OT)-A indicated, she had worked with R703 on 12/3/18 on toileting and R703 required contact guarding to the toilet and required moderate assistant with dressing. OT-A stated she notice some bruising, but it was more to the side then on the back.

An undated facility policy and procedure titled SKIN INTEGRITY PROTOCOL FOR NURSES, directed staff, "1. Update nurse manager and /or House Supervisor upon discovery of all new skin alterations which includes bruises, pressure ulcers, diabetic ulcers, vascular ulcers, skin tears,

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2 830	Continued From page 10 blisters, lacerations and surgical wounds. 2. Notify MD/NP to obtain new wound treatment orders. 3. Notify the resident/legal representative of the new wound/skin alterations. 4. Complete skin alteration progress note in PCC [point click care] and complete a risk management UDA (pressure ulcers/skin tears) ..." Based on observation, interview, and document review, the facility failed to implement interventions listed on the care plan to prevent spilling of hot beverages for 1 of 5 residents (R109) reviewed for accidents. Findings include: R109's quarterly Minimum Data Set (MDS) dated 10/26/18, identified R109 had severe cognitive impairment with diagnosis of dementia and muscle weakness. The MDS further identified R109 eats and drinks with supervision. R109's care plan revised on 11/5/18, identified R109 can feed self-following set-up, with supervision at meals. R109's care plan indicated R109 utilized a spouted mug with cover when served hot liquids R109's progress note dated 11/05/18, indicated during weekly shower a fluid filled blister was noted on mid-thigh. The progress note indicated that R109 reported she got burned a couple days ago, R109 is right handed and likes to drink hot coffee. Progress note indicated care plan revised for spouted cup with lid for hot beverages. During observation on 12/04/18, at 3:23 p.m. R109 was sitting at dining table in her wheelchair eating a Christmas cookie, R109 dropped her regular uncovered coffee cup, spilling coffee on	2 830		

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2 830	Continued From page 11	2 830		

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 practitioner were updated regarding the spill.

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2 830	Continued From page 12 On 12/06/18, at 8:54 am R109's skin was assessed by writer and RN-A and RN-D, no redness or blisters were noted. When interviewed on 12/06/18, at 8:54 am with TC-B stated the therapeutic recreation staff just recently started to print a new list before each activity from point click care which not only lists diets, but special adaptive equipment if needed. When interviewed on 12/06/18, at 9:20 am RN-A stated the spouted cups with the cover come from the kitchen, RN-A went on to say it is also on meal ticket. At coffee time, the TC prints a daily diet list that has that information on it. RN-A stated typically the cups with lids should be available on the unit in the kitchenette. When interviewed on 12/06/18, at 10:08 am nursing assistant (NA)-F stated she would know that R-109 needed a spouted cup with a lid because it is on the meal ticket from the kitchen and in R-109's care plan. A policy was requested for following care plans, no policy received. SUGGESTED METHOD OF CORRECTION: The director of nursing (SON) and/or designee could review and review facility policies regarding assessment for wheelchair position, oxygen tubing change procedures, monitoring of bruising and skin changes and accident prevention/safety. The DON or designee could educate staff, perform audits to ensure care needs are met in each of these areas. The DON or and report findings to the facilities quality assurance (QA)	2 830		

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2 830	Continued From page 13 committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure Prevalon boots (pressure relieving foam boots) were used consistently to reduce pressure for 1 of 3 residents (R141) reviewed for pressure ulcers. Findings include: R141's significant change Minimum Data Set (MDS) dated 11/16/18 indicated R141 had significant cognitive impairment and required	2 900	Completed.	1/15/19

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2 900	Continued From page 14 extensive assistance with activities of daily living including dressing, grooming, bathing, and mobility. The MDS identified R141's medical diagnoses to include: cancer, anemia, heart failure, peripheral vascular disease (A blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.) diabetes, right hip dislocation, arthritis, and pain. R141's care plan revised on 12/3/18, indicated R141 was at risk for developing a pressure ulcer related to bowel incontinence, decreased mobility related to right hip dislocation, lack of understanding/compliance with turning and repositioning needs, a history of pressure ulcers, and a blood blister on left great toe. The care plan directed staff to ensure R141 has his blue Prevalon boots on while in bed. On 12/06/18, at 8:37 a.m. R141 was observed in bed lying on his back with a footboard at the foot of the bed, supporting blankets off of feet, however, his Prevalon foam boots were not in place on his feet, boots were sitting on his wheelchair. On 12/06/18, at 11:25 a.m. R141 remained in bed at this time, in a back lying position. R141's Prevalon foam boots continued to be on his wheelchair. On 12/06/18, at 11:51 a.m. A registered nurse (RN)-L stated R141 was to have his foam boots on while in bed as the foam boots were worn to prevent pressure ulcers, primarily in the heels/ankles. RN-E stated the use of the foam boots were recommended to be used as outlined in the care plan.	2 900		

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2 900	Continued From page 15 On 12/06/18, at 12:05 p.m. nursing assistant (NA)-H stated R141's boots were not on at the beginning of her shift. NA-H stated although she had assisted R41 with change of incontinence brief, she did not wish to fully awaken resident to ask if he would wear his boots. On 12/06/18, at 12:09 p.m. RN-L stated R141's boots were to be in place at all times. RN-L stated if personal cares were completed, R141's foam boots should have been applied at that time. On 12/06/18, at 12:59 p.m. family member (FM)-B stated R141 was to wear his boots at all times. FM-B stated she had removed his boots last night to give him some time to move his feet and had not reapplied them prior to leaving. A policy was requested for proper use and application of pressure relieving devices was requested but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		1/15/19

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2 910	Continued From page 16 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that an indwelling catheter was changed according to physician orders for 1 of 3 residents (R99) reviewed with an indwelling Foley catheter. Findings include: R99 quarterly Minimum Data Set (MDS) dated 10/25/18, indicated R99's diagnoses included obstructive and reflux uropathy (urine cannot drain through the urinary tract), history of urinary tract infection (UTI), and retention of urine, benign prostatic hyperplasia (BPH) (enlarged prostate) and chronic kidney disease. MDS indicated R99 was cognitively intact. R99's care plan printed on 12/06/18, indicated R99 has a Foley catheter due to obstructive	2 910	Completed.	

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2 910	Continued From page 17	2 910		

uropathy, BPH, urinary retention and frequency. R99 is being seen by a urologist and is at risk for retention and UTI. Last hospitalized 8/8/18 with a UTI.

Review of R99's Order Summary Report dated 10/31/18, directed Foley to be changed at urologist's office every month, starting on the 25th for 28 days. R99 had a physician's order to change 16F 5 cc balloon as needed (PRN) if clogged and unable to flush.

Review of R99's patient visit note from urologist dated 11/28/18, indicated if there are any significant cardiac concerns, would continue Foley drainage for now and forego the supra pubic catheter placement and continue catheter change every 4 weeks.

When interviewed on 12/05/18, at 1:00 p.m. R99 stated he had to see a special doctor for his catheter on 11/28/18, R99 went on to say the plan was to have a supra pubic catheter placed on 12/07/18, but is not able to due to concerns from his cardiologist. R99 stated he thought it had been over a month since he had his catheter changed. R99 stated he had problems with urinary tract infections and problems with his catheter getting plugged, R99 went on to say that the nursing home has had difficulty changing his catheter in the past and needed to go to the urologist every month for it to be changed.

During interview on 12/05/18, at 1:22 pm registered nurse (RN)-E stated R99's catheter should have been changed on 11/28/18 when R99 went to see the urologist. RN-E reviewed the visit note dated 11/28/18, which indicated R99 was only seen for a consult for supra pubic catheter placement. RN-E stated at that time the

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2 910	Continued From page 18 urologist had not spoken to the cardiologist. RN-E went on to say the surgery had been canceled for the supra pubic catheter on 11/30/18. RN-E looked at the electronic treatment administration record (ETAR) for November 2018, which indicated R99's last catheter change was on 11/02/18 at the nursing home per the PRN order. RN-E checked the appointment book to see if a urology appointment was scheduled for a catheter change, the schedule lacked a future appointment. RN-E stated an appointment should have been scheduled and it must have been missed. RN-E stated R99's ETAR indicated the catheter should be changed every 28 days. RN-E stated she would call the urologist office to follow up and see if monthly changes needed to be in office or if it could be done at the nursing home. During interview on 12/06/18, at 1:16 p.m. health unit coordinator (HUC)-C stated when a resident goes to an outside appointment a visit referral and an order sheet will go with. HUC-C went on to say at times they may come back with notes and recommendations on their own form. HUC-C stated the notes and recommendation are given to the nurse manager to review before she can put in any orders or schedule any appointments. A policy was requested, none received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders to assure completion of ordered referrals are completed to prevent ordered referrals are provided. The director of nursing or designee, could conduct random audits of physician orders to ensure appropriate care and services are implemented.	2 910		

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2 910	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide routine personal grooming for 2 of 4 residents (R151, R141) reviewed for activities of daily living (ADL's) and who were dependent on staff for their care. Findings include: R151's diagnosis included diabetes, chronic kidney disease, and dementia. R151's quarterly Minimum Data Set (MDS) dated 11/18/18, indicated R151 was cognitively impaired. R151's MDS indicated R151 needed extensive assistance from staff with personal hygiene. R151's care plan dated 11/19/18, indicated R151 needs extensive assistance from one staff for grooming and hygiene needs. During an observation on 12/4/18, at 9:37 a.m.	2 920	Completed.	1/15/19

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2 920	Continued From page 20	2 920		

R151 had approximately 15 white chin hairs 1/4 to 1/2 inch in length. R151 stated it bothered R151 to have chin hairs.

During subsequent observation on 12/4/18, at 3:36 p.m. and 12/5/18, at 7:09 a.m. R151 continued to have 1/4 to 1/2 inch long white chin hairs.

During an observation on 12/5/18, at 7:46 a.m. nursing assistant (NA)-A and NA-C where assisting R151 with morning cares. NA-A brought R151 to the sink in the room and assisted with brushing R151's teeth. NA-A combed R151's hair, took the hair out of the comb and threw it in the garbage and then took the disposable razor and threw it in the garbage. R151 chin hairs were not removed and NA-A took R151 to the dining room.

During an interview on 12/5/18, at 8:33 a.m. NA-C stated we should shave the residents who want to be shaved, even the women. NA-C stated we would use a disposable razor for the women.

During an interview on 12/6/18, at 8:23 a.m. NA-A stated female residents should be shaved if they have chin hairs. NA-A confirmed R151 had not had the chin hairs removed prior to breakfast.

During an interview on 12/6/18, at 9:28 a.m. licensed practical nurse (LPN)-A stated with morning cares the expectation of staff was to shave the residents who were in need of shaving. LPN-A stated R151 does allow the staff to shave R151.

When interviewed on 12/6/18, at 1:32 p.m. the director of nursing (DON) stated if female

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2 920	Continued From page 21	2 920		

residents want chin hairs cleaned up then we should be doing that for them. The DON stated we should have offered R151 to have the chin hairs cleaned up.

A facility policy was requested, however none was provided regarding personal cares.

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 may increase his risk for recurrence for urinary tract infections. R141 was also identified as incontinent of bowel and an incontinence brief was used. R141's care plan also indicated R141 was at risk for developing a pressure ulcer related to bowel incontinence, decreased mobility related to right hip dislocation, lack of understanding/compliance with turning and repositioning needs, and history of pressure ulcers and had a blood blister on his left great toe. The care plan directed staff to ensure R141 has his blue Prevalon boots on while in bed.

On 12/06/18, at 8:37 a.m. R141 was observed in his room, in bed with his eyes closed. R141's head of the bed was elevated to approximately a 45 degree angle. A smell of urine was pronounced upon entering the resident room. R141's urinary catheter bed bag was observed

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2 920	Continued From page 22	2 920		

covered and hanging on the bed frame. R141's foam boots were in the chair next to the bed.

On 12/06/18, at 11:25 a.m. R141 was observed in his room resting under the covers on his bed. R141's eyes were closed. Urinary catheter tubing was observed to attach to bed bag which was connected to the bed and was covered. A more pronounced urinary odor was noted at this time. R141's foam boots remained on the chair.

On 12/06/18, at 11:51 a.m. registered nurse (RN)-L stated she could smell a urinary odor. RN-E joined surveyor and RN-L in the room and noted the urinary odor. RN-L stated there could be bypassing of the catheter (Leaking around the catheter) which was indicative of the need to change the catheter. RN-L proceeded with provision of care for R141. RN-L stated there should not be an odor as it was a closed system. RN-L also stated the odor could indicate the signs of an infection or dehydration. RN-L stated when bypassing was noted this should be reported to the nurse as the catheter was not functioning properly. RN-L stated she had not been informed of the catheter bypassing. RN-L also commented being wet was uncomfortable and could cause skin breakdown, as well as the odor being noticeable to others, adding no one wants to stay in the room with the smells. RN-L stated R141's foam boots should be in place on both feet when resident is in bed due to the potential for skin breakdown.

On 12/06/18 at 12:05 p.m. nursing assistant (NA)-H stated she had provided R141 with personal hygiene this morning. NA-H stated the odor of urine improved with provision of personal hygiene but was still noticeable. NA-H stated she had informed RN-L of the urinary odor and the

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2 920	Continued From page 23 bypassing of the catheter. NA-H had stated the foam boots were not in place this morning and she did not wish to waken R141 to inquire if he wished to wear his foam boots, although stated she had performed personal hygiene and pericare for incontinence. On 12/06/18, at 12:59 p.m. family member (FM)-B stated R141 has had his indwelling catheter for over six months and has experienced urinary tract infections. FM-B stated she has observed urinary sediment in the tubing and has observed the urine to be dark in color. FM-B stated she had not observed a personal odor today but stated R141 would be "offended by the whole thing." FM-A stated "I would be upset by the presence of a personal odor if others could smell urine in the room." FM-B stated she had removed R141's boots last night. FM-B stated the foam boots were in place to prevent pressure concerns. The policy related to Foley catheter use and how to maintain dignity was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could develop/revise pertinent policies and procedures related to grooming, audit resident care to ensure grooming needs are met and educate staff on the importance of grooming needs. The results of the audit could be reported during the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920		

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21330	Continued From page 24	21330		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide routine dental services for 1 of 2 residents (R64) reviewed for dental services Findings include: R64's diagnosis included ulcerative colitis, liver disease, and depression. A quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R64's cognition was intact. R64's quarterly Pain Interview; Balance and ROM (range of motion); Oral/Dental Status-V2 dated 10/2/18, indicated R64 was not asked does the	21330	Completed.	1/15/19

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21330	Continued From page 25	21330		

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 12/13, indicated residents shall be offered dental services as needed.

SUGGESTED METHOD OF CORRECTION:

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21330	Continued From page 26 The director of nursing or designee could educate staff regarding the need to offer dental services to residents. The director of nursing or designee could develop and auditing system to monitor ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21330		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure a residents wheel chair was clean and sanitary for 1 of 1 residents (R138) reviewed for environment. Findings include: R138's quarterly Minimum Data Sets (MDS) dated 11/11/18, indicated R138's diagnosis included, severely impaired cognition, hypertension (elevated blood pressure), depression and Parkinson (chronic progressive neurological disease). R138 required a wheel chair for mobility with staff to propel to all locations. R138's care plan dated 12/6/18, indicates R138 required extensive assistance with all his	21665	Completed.	1/15/19

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21665	Continued From page 27 activities of daily living. During observation on 12/3/18, when observing R138's wheelchair, it was noted to have dried white substance and a sticky looking clear substance on the frame and covers of the wheel chair. During observation of R138's wheelchair during the dates of 12/3/18 through 12/6/18, R138 continued to have an unclean wheelchair with old dried food and dried liquid on the chair. During interview on 12/6/18, at 11:36 a.m. nurse assistant (NA)-G stated R138's wheelchair is dirty and needs to be cleaned. During interview on 12/6/18, at 11:45 a.m. licensed practical nurse (LPN)-B stated R 138's wheelchair is dirty and needs to be cleaned. LPN-B stated nurses are supposed to wipe the wheel chair down when viably soiled. LPN-B stated nursing has a cleaning list and R138's name is on the list, however it is not initialed as having been cleaned. During record review of the Wheelchair Washing Schedule, R138's name was on the list to have wheelchair washed, however it is not initialed as done or clean. A facility policy for Cleaning and Disinfection of Resident-Care Items and Equipment dated revised 2014, indicates resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.	21665		

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21665	Continued From page 28 The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were provided care in a dignified manner, and free from personal odor for 2 of 5 residents (R705 and R141) who used catheters and were reviewed for urinary incontinence. Findings include: R705's admission record indicated, R705 was recently admitted to this facility with diagnosis that included overactive bladder, malignant neoplasm of prostate, Parkinson's disease, major depressive disorder and hypertension.	21805	Completed.	1/15/19

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21805	Continued From page 29 On 12/6/18 at 8:29 a.m., R705 was observed sitting in wheelchair eating breakfast with an uncovered urinary drainage bag with condom hooked to it hanging on the left end of the recliner chair. R705's door was observed to be wide open, as staff and visitors passed by. There was a personal aide (PA) sitting in the room at the time. The urinary drainage bag was observed to contain approximately 200 milliliters of urine. R705 verbalized that drainage bag with urine hanging on the recliner was bothersome. The PA indicated, facility staff get resident ready around 7:30 a.m., but did not empty nor clean the drainage bag. On 12/6/18 observations were conducted between 8:40 a.m. and 9:08 a.m., R705 was still observed sitting in wheelchair with an uncovered urinary drainage bag with condom hooked to it hanging on the left end of the recliner chair. R705's door was observed to be wide open, as staff (NA-D, NA-E, RN-I), residents and visitors passed by. The urinary drainage bag was observed to contain approximately 200 milliliters of urine. At 9:07 a.m., NA-D went to R705's room and transferred R705 from the wheel chair to the recliner chair but did not remove, empty and clean the drainage bag that was hanging on the left side of the recliner chair. At 9:15 a.m., PA indicated, she reminded NA-D about emptying and cleaning the drainage bag but NA-D did not empty or clean the drainage bag with urine. At 9:16 a.m., R705 expressed dislike of drainage bag with urine hanging on the recliner chair. On 12/6/18 observations were conducted between 9:16 a.m. and 10:35 a.m., R705 was still observed sitting in recliner chair with an uncovered urinary drainage bag with condom	21805		

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21805	Continued From page 30	21805		

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 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 may increase his risk for recurrence for urinary

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21805	Continued From page 31	21805		

tract infections. R141 was also identified as incontinent of bowel and an incontinence brief was used. The care plan directed staff to to assist with catheter cares every shift and as needed. The care plan directed staff to manage catheter and update the the medical doctor (MD) or nurse practitioner (NP) as needed.

On 12/06/18, at 8:37 a.m. R141 was observed in his room, in bed with his eyes closed. R141's head of the bed was elevated to approximately a 45 degree angle. A smell of urine was pronounced upon entering the resident room. R141's urinary catheter bed bag was observed covered and hanging on the bed frame.

On 12/06/18, at 11:25 a.m. R141 was observed in his room resting under the covers on his bed. R141's eyes were closed. Urinary catheter tubing was observed to attach to bed bag which was connected to the bed and was covered. A more pronounced urinary odor was noted at this time.

On 12/06/18, at 11:51 a.m. registered nurse (RN)-L stated she could smell a urinary odor. RN-E joined surveyor and RN-L in the room and noted the urinary odor. RN-E thought it may be coming from the black cloth bag covering the catheter bag. RN-L stated there could be bypassing of the catheter (Leaking around the catheter) which was indicative of the need to change the catheter. RN-L proceeded with provision of care for R141. RN-L stated there should not be an odor as it was a closed system. RN-L also stated the odor could indicate a sign of an infection or dehydration. RN-L stated when bypassing was noted this should be reported to the nurse as the catheter was not functioning properly. RN-L stated she had not been informed of the catheter bypassing. RN-L also commented

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21805	Continued From page 32 that being wet was uncomfortable and could cause skin breakdown, as well as the odor being noticeable to others, adding no one wants to stay in the room with the smells. On 12/06/18 at 12:05 p.m. nursing assistant (NA)-H stated she had provided R141 with personal hygiene this morning. NA-H stated the odor of urine improved with provision of personal hygiene but was still noticeable. NA-H stated she had informed RN-L of the urinary odor and the bypassing of the catheter. On 12/06/18, at 12:59 p.m. family member (F)-B stated R141 has had his indwelling catheter for over six months and has experienced urinary tract infections. F-B stated she has observed urinary sediment in the tubing and has observed the urine to be dark in color. F-B stated she had not observed a personal odor today but stated R141 would be "offended by the whole thing." FM-A stated "I would be upset by the presence of a personal odor if others could smell urine in the room." The policy related to Foley catheter use and how to maintain dignity was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all staff on resident dignity and respect. The director of nursing or designee could perform random audits to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the	21830		1/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00261	A. BUILDING: _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 34	21830		

resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social

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21830	Continued From page 35 service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accommodate bathing preferences for 1 of 4 residents (R64) reviewed for choices. Findings include: R64's diagnosis included ulcerative colitis, liver disease, and depression. A quarterly Minimum Data Set (MDS) dated 10/3/18, indicated R64's cognition was intact. On 12/3/18, at 3:53 p.m. when asked if R64 was able to choose how often he bathed, R64 stated I only get one shower on Wednesday. R64 stated that R64 had not asked for more showers and was not offered any more. R64's care plan dated 9/25/18, indicated R64 received one shower a week and needed supervision. During an interview on 12/5/18, at 9:20 a.m. with nursing assistant (NA)-B stated the residents have to request another bath or shower before they can receive another bath or shower. NA-B stated the bath or showers are listed on the Nursing Assistant Care Guide. NA-B stated no	21830	Completed.	

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21830	Continued From page 36 resident has two baths or showers on hall two. During an interview on 12/5/18, at 9:33 a.m. with NA-A stated if a resident asks for another bath or shower I would tell the nurse and they would schedule it. NA-A stated residents would have to ask for another bath or shower they are not schedule automatically. 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. During an interview on 12/5/18, at 1:27 p.m. with RN-F stated residents could have more than one bath or shower a week they have to request it. RN-F stated we not ask regularly if the residents would like more baths or showers. A policy was requested for scheduling baths or showers none was provided. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		